

STATE EFFORTS TO INCREASE THE AVAILABILITY AND AFFORDABILITY OF HEALTH INSURANCE

HEARING BEFORE THE SUBCOMMITTEE ON ANTITRUST, IMPACT OF DEREGULATION, AND PRIVATIZATION OF THE COMMITTEE ON SMALL BUSINESS HOUSE OF REPRESENTATIVES ONE HUNDRED FIRST CONGRESS SECOND SESSION

TULSA, OK, AUGUST 10, 1990

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FRIDAY, AUGUST 10, 1990

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ANTITRUST,
IMPACT OF DEREGULATION AND PRIVATIZATION,
COMMITTEE ON SMALL BUSINESS,
Tulsa, OK

The committee met, pursuant to call, at 9:30 a.m., in the Aaronson Auditorium, Tulsa City/County Public Library, Tulsa, Oklahoma, Hon. Dennis E. Eckart (chairman of the subcommittee) presiding.

Chairman ECKART. The Subcommittee on Antitrust, Impact of Deregulation and Privatization's Tulsa, Oklahoma, hearing on health insurance will be called to order. My name is Congressman Dennis Eckart. I serve as the subcommittee chairman, and I am delighted to have this opportunity to be here in Tulsa today. This is the fifth in a series of hearings that our subcommittee has held, focusing on the problems relative to small business dealing with high health insurance rates. There is no more pressing problem for small businesses. In fact, this Nation spends approximately 11 percent of its gross national product—the highest percentage of any nation in the world—on the provision of health care for its citizens.

The purposes of these hearings, which have been conducted over the past 2 years, is to come to communities and States which have been hard hit by the prices, to look at innovative State and local solutions and to how those solutions when successfully implemented can be made part of a national answer. Washington, in many respects, has been paralyzed by this problem, and the States such as Oklahoma have, indeed, taken the lead in offering innovative solutions.

We advised each of the members of the subcommittee to attend this hearing. Of course, we have also invited each of the members of the Oklahoma delegation to attend and participate. It is my understanding that they may have written statements to submit as part of the record, and without objection, these will also be made part of the record.

The purposes of these hearings, as I stated, is to develop an agenda by which the Congress can respond to the peculiar needs of small businesses as it relates to rapidly escalating health insurance costs. The average American spends more than \$2,100 a year for health care. Small businesses, small employers have been particu-

larly hard hit. For small businesses, finding affordable health care is like grocery shopping in eastern Europe—long lines, ridiculous prices, and very little, if anything, on the shelves.

There are many in Washington who advocate national health insurance programs. There are others who suggest that the cost of providing the coverage for the 30-37 million Americans who do not have health care ought to be pushed back simply on the remaining employers in our community.

But, what is very clear to this gentleman is that the deck is stacked against small business. Rates for all companies in health care rose approximately 20 percent last year. But for smaller firms, that increase was 30-40 percent. But increasingly, cost is not even the problem. Insurance providers are simply dumping whole blocks of coverage, leaving small businesses to scramble for coverage themselves. They end up paying much more for less.

What drew us particularly to Oklahoma is the serious nature of the problem that your State has experienced in the last several years and the fact that Oklahoma has done more than most other States to help themselves. Frequently, one of the most important things Congress can do is leave the confines of the beltway and find innovative efforts that really have worked. Our first panel will help us with that today.

It is my understanding that Oklahoma, in the past, has seen certain booms and busts, but health care hit you all real hard, and we want to find out what you have done that has helped deal with this crisis here.

It is my clear impression that small businesses asked for a solution, and they need one now. Congress intends to be acting in these matters, but with only a few weeks left in the balance of this session we are obliged to focus on the next session.

As I mentioned at the opening of my remarks, we have at least one written statement to submit on behalf of another member of the delegation and the subcommittee. I understand we share this community with another Member of Congress. But one of them is here with us today, my colleague, Congressman Mike Synar, and I would like to recognize him for such opening remarks as he may wish to make.

Mr. SYNAR. Thank you very much, Dennis. First of all, let me welcome you to Tulsa, Oklahoma. Though we are not sitting in my district, you go approximately a couple of miles south of here and you would, and I know that the rest of the members of the delegation from Oklahoma are very grateful for you being here today.

I would like to at the outset—I know that we have some people outside—to try to invite them to come in because one of the reasons we have Dennis and the Small Business Antitrust Subcommittee here today is to give everyone in northeastern Oklahoma the opportunity to see first hand Members of Congress and express their concerns about this very vital issue of health care. So, for anyone who is outside, we would like them to come in and be part of this hearing today.

Here in Oklahoma, we have one of the Nation's highest rates of working people who have no health insurance. Business people have responded to this crisis by developing some creative solutions. The problems we face in Oklahoma can be seen as a microcosm of

the problems people face across this Nation. The solutions developed here should be kept in mind as we as a Nation begin to formulate national solutions to this problem.

Now, there is some anxiety in the small business community over the possibility of Government mandating health benefits. But, I am not certain that is the right approach to solving the problem of the vast number of uninsured workers in this country because currently, the cost of such insurance is too high. A solution must be found, I think, through a cooperative effort of our insurance industry, businesses, the medical community, and Government, in general.

The problem of access to health care and insurance is multifaceted. Businesses are trying to do the best they can. But for many, the cost of providing health-care insurance to employees is prohibitive.

For example, one constituent of mine contacted our office about the problem he was having. He feels health insurance is important, but it takes 20 percent of his payroll to provide health insurance to his employees. It is difficult for him to remain competitive with the business down the street that pays their employees just 25 cents more, but provides no health insurance. He has lost employees who found that slightly higher pay was more valuable to them than health insurance.

Americans do not appreciate the value of health insurance, and many people would prefer those extra few cents an hour over a good health-insurance policy. Regrettably, too many people do not see the reason to have health insurance until they need it. By then, they are usually unable to get health insurance because they had a preexisting illness.

People should look at the health insurance in this country the same way we do car insurance. In Oklahoma, car owners are required to have insurance before they can drive a car. When you buy a car, you figure the price of insurance into the cost of that car. We should approach health insurance in the same way by planning it into the family budget as a normal cost of living. Getting every person in this country insured and keeping them insured would benefit us all.

We also need to change the attitude toward health care so that the focus is on preventative health care. Too often, people seek medical care only when they have a problem. Everyone should go in for regular care, instead of waiting until a serious problem exists. This basic step would reduce the cost of health care and the insurance for all of us.

I do not have all of the answers. I want input so that we can work together to find those solutions. That is why we are here today, and that is why I am grateful that Dennis could take time out of his busy schedule to hold this hearing. I want to be able to return to Washington with more ideas and suggestions from people who face these problems. Business, the insurance industry, consumers, the medical community, and Government must all work together to find a solution.

[Mr. Synar's statement may be found in the appendix.]

Chairman ECKART. Welcome to our first panel. I will introduce them and proceed in the following order. But, before I do so, it would be remiss of me if I did not thank the office of one of your

Senators, Michael, Senator David Boren. All too often when Congress goes on the road, we need a place to work out of, and Senator Boren's staff was extremely helpful. In fact, I understand they opened their office about 7 a.m. this morning to help us make Xerox copies of material and to have access to the fax machine, both so that I can stay in touch with recent developments in the Middle East and to make sure that we had a hearing that was well coordinated. So, to the Senator, who, of course, has a number of other pressing matters before him—particularly as Chair of the Intelligence Committee—this subcommittee and the House wants to thank him.

Our first panel is a distinguished panel indeed. It consists of Senator Ted Fisher—whom I understand has served 4 years in the Oklahoma Senate, 2 years as a Chair of the Senate Economics Development Committee, and author of the Health Insurance Opportunities for Employed Uninsured Oklahomans Act.

The next member of our panel is Mr. Brett Dickey, director of the actuarial department representing the Oklahoma Insurance Department.

Mr. Horkey, retired executive vice president and president of the Tulsa Business Health Group and vice chair of the Oklahoma Council on Health Care Delivery. Mr. Horkey worked with Tulsa Health Option and with the Tulsa Chamber of Commerce. I look forward very much to your testimony and would like to compare it with what the Chamber of Commerce has done in Cleveland, which now provides insurance for 44,000 employees and 76,000 dependents—folks who would not have health care coverage, and it has been a little piece of the program that has worked.

Commissioner Lyons from the Iowa Department of Insurance and represents, I understand, the National Association of Insurance Commissioners, an association of insurance officials of each State and territory. You have suggested some model legislation, which I think can be extremely helpful, and hopefully, we can discuss that.

Senator, if we may first, we would like to begin with you, and then, Commissioner, we will come to you. Senator Ted Fisher.

TESTIMONY OF HON. TED FISHER, OKLAHOMA STATE SENATOR

Mr. FISHER. Thank you, Mr. Chairman, and I do, indeed appreciate—

Chairman ECKART. Excuse me, Senator. Commissioner, could we get the microphone down to Senator Fisher so those who are here can hear. That is about as good as we are going to get there, Senator.

Mr. FISHER. I do appreciate this subcommittee being in Oklahoma today on this most serious problem that needs your concern. My name is Ted Fisher. I am a resident of Sapulpa, Oklahoma, and a Member of the Oklahoma State Senate, representing District 12 which borders the Tulsa area. I have served in the Senate for the last 4 years and have served as chairman of the State Economic Development Committee for the last 2 years.

My interest in Oklahoma's business development, my familiarity with the insurance industry, and my deep concern about the growing cost of uncompensated health care prompted my introduction

in 1989 of a bill to make insurance more accessible to Oklahomans, Senate Bill 346. My purpose here today is to explain the provisions of Senate Bill 346 and to provide insight into issues considered and decisions made as the bill developed.

In October 1988, the Oklahoma Medical Research Foundation, Center for Health Policy Research, published a report entitled Medical Security in Oklahoma. The report found that Oklahoma had one of the highest rates of uninsured citizens in the Nation and placed the blame on two factors: One, current standards prevented a large number of impoverished Oklahomans from qualifying for Medicaid; and two, adequate and affordable health insurance was not available in the work place.

The report estimated that 636,000 persons in Oklahoma were medically uninsured. Of that number, an estimated 536,000 were the working uninsured and their dependents, estimated at 400,000 by other sources, and 100,000 were the unemployed and their dependents. Overlapping this population were the uninsured poor estimated at 245,000 persons. Included in the medically uninsured population are 30,000 persons which the report categorizes as uninsurable. I have heard figures as high as 40,000 to 50,000 for this population. The medically uninsured represent 22.8 percent of Oklahoma's nonelderly, civilian population—

Chairman ECKART. As much as 22.8 percent?

Mr. FISHER. Correct.

Chairman ECKART. That has to make you one of the highest in the country.

Mr. FISHER. Exactly; the figures were based on 1986 data. A figure which was considerably higher than the median rate of 16.9 percent for all States and the District of Columbia.

We all know that free health care does not exist. Someone else pays the bill for the medically uninsured, whether it be through higher insurance costs for those who purchase insurance, higher medical charges to those who can pay, higher taxes to pay for social services or unprovided medical services. The report assessed the impact of this health care cost shifting by using the unsponsored care ratio, a measure which calculates the percent of hospital expenses which are shifted to private payors or absorbed by the hospital. For Oklahoma, the rate was 7.36 percent, which was the sixth highest ratio in the Nation. The national rate was 4.79 percent.

The health-care system is dependent upon the ability of patients to pay for services. Few, if any, citizens can pay for extensive health-care services unless they are covered by health insurance. As the uninsured population increases, the viability of the health-care system is threatened. The high percentage of uninsured and the comparatively high rate of cost shifting in Oklahoma is, indeed, cause for alarm.

It would be wonderful if we could ensure the availability of insurance for all persons, whether they were employed or unemployed, healthy or disabled, young or old. Some States have chosen to create State-backed, high-risk pools for the uninsurable. Others have chosen to mandate that employers provide insurance for their employees. Oklahoma has not taken either of these approaches.

As a rule, Oklahomans are very skeptical of the Government's ability to succeed where private industry has been less than successful. Passage of legislation which created a State-run program to provide insurance for the 636,000 medically uninsured or mandated that employers provide insurance was not a viable option, in my opinion.

Estimates placed the cost of providing health care for the uninsurable population, 30,000 to 50,000 persons, at close to \$1 billion. With a State budget of \$3.24 billion, the price tag for solving this portion of the problem was beyond our means at this time. Therefore, rather than tackle the entire problem, I chose to address the portion that I thought had the greatest opportunity for resolution, the working uninsured. We had two options: mandate insurance or provide incentives to encourage its purchase. I opted to address the problem by providing the right product for the right price and incentives to purchase the product.

Senate Bill 346 was not the result of my efforts alone. Other legislators, particularly Senator Howard Hendrick and Representatives Steve Lewis and Cal Hobson, were actively involved in the bill's development. Additionally, in 1989, Governor Bellmon formed a task force of concerned business leaders, community leaders, and insurance industry representatives, under the direction of Richard J. Gilbertson of the Oklahoma Employment Security Commission, to recommend a plan for making low-cost insurance available to the working uninsured.

During the interim between the 1989 and 1990 sessions, under the leadership of Robert Fulton, Secretary of Social Services for Oklahoma, the Governor's task force, and the legislators and consultants involved with Senate Bill 346 met to hammer out differences and to develop a basic health benefits plan and method for offering that plan to working Oklahomans. The work of this consortium of interested parties produced the final version of Senate Bill 346, the Health Insurance Opportunities for Employed Uninsured Oklahomans Act—quite a mouthful, I might say—which became law in May of this year.

Senate Bill 346 represents a partnership between Government and the insurance industry. Under the act, a public board is appointed to design a basic health benefits plan. The plan is offered to employers by private insurers who are certified by the board to offer the plan. A refundable tax credit is used as inducement to employers to purchase the plan. The act does not create a public insurance company. The act does not make insurance coverage mandatory.

Several basic issues were addressed and resolved before the design of the act was finalized. Some of these issues were: who should be eligible for the plan; to what degree should Government be involved in designing, marketing, and reserving the plan; which benefits should be included, excluded, or limited; and what cost should Government bear.

Let me address eligibility first. The parties involved in the legislation's design intended that the health insurance be made available to employers who had previously been unable to provide insurance for their employees. The insurance plan offered under this act would not be a deluxe model. It would be a plan that would offer

basic health benefits at a minimum price. Keeping the price affordable would be a high priority. Therefore, we did not want to create a situation in which employers who were able to afford better coverage for their employees and, in fact, had provided that coverage would drop their current policy to purchase the State-certified plan. We wanted to target a market that the insurance industry had largely ignored, but not cut in-roads into the market already served by the insurance industry.

The legislation was drafted with language to accomplish this intent. An eligible employer was defined as one who had done business in the State for a year or more and was not providing health insurance for at least 75 percent of its employees. To discourage employers from dropping coverage to become eligible, language was added which excluded employers from eligibility for a 15-month period prior to the offer to purchase the State-certified plan.

We debated whether to limit eligibility to small businesses, as other States, such as Oregon, had done. On one hand, we felt the primary target for a low-cost, basic health benefits plan should be small businesses who are at least able to afford health insurance for their employees. However, our other concern was making insurance available to employees and their dependents who currently did not have access to coverage. Limiting eligibility to small businesses was contrary to our objective of providing accessibility to as many uninsured as possible. In addition, enlarging the pool of eligibles allowed a greater spreading of risk and decreased the possibility of adverse selection.

The legislation requires that the State-certified plan be offered through employers to their employees and dependents. The plan is designed as group coverage, and minimum participation requirements, based on the number of workers employed, are included in the legislation. Employees qualify for coverage if they are State residents, work a minimum of 24 hours a week and are not covered by a group health insurance plan offered by their employer.

Our next major hurdle was determining the extent to which the Government should be involved in the administration and delivery of the plan. Our debate ranged from creating a State agency which would operate like an insurer similar to our State Insurance Fund which provides workers' compensation, to creating a board, similar to our State Education Employees Group Insurance Board, which would contract with a third-party administrator to perform insurance functions and would manage reserve funds for the plan, or to creating a board which would design the benefits plan, but would contract with either a single or unlimited number of insurers to offer the plan and assume all responsibility for adequately reserving the plan. In fact, each of these concepts appear in the various versions of the bill.

The final version of Senate Bill 346, as enacted into law, creates an 11-member Oklahoma Basic Health Benefits Board. The board will design the plan which will involve determining minimum benefits, scope of coverage, maximum premium amounts and other provisions, such as coinsurance, deductibles, payment schedules, and lifetime benefits.

Although the bill leaves the overall responsibility of designing the plan to the board, it does specify certain benefits that must be

included, as well as limitations and exclusions. As an example, coverage for cosmetic surgery, chronic fatigue treatment, obesity remediation is excluded. Transplant coverage is limited to certain procedures. Payment limitations for preexisting conditions are specified. Prenatal care is specifically included and not subject to any deductible, copayment or preexisting condition exclusion. With the exception of businesses comprised of two or less persons, the plan is prohibited from requiring evidence of insurability. The plan may not vary premiums or benefits by age.

The inclusion and exclusion of these benefits were based on actuarial studies conducted to determine the feasibility of a low-cost, basic health benefits plan. These studies support the belief that a plan can be designed which offers basic health care coverage for a cost of approximately \$60 a month for each adult participant.

The board will certify insurers to offer the plan, who then will market the plan to employers under their policy. The policy must include the minimum benefits approved by the board and will not be required to include any other State-mandated benefits, which in essence, cuts out our insurance commissioner from supervision of the plan. Benefits cannot be reduced and premiums cannot be increased unless the insurer receives prior approval from the board. The insurer will assume all liability for maintaining adequate reserves and for paying all claims.

The board is responsible for establishing a grievance procedure to hear complaints from participants in the plan. The board is also responsible for conducting a promotion campaign to make employers and employees aware of the plan and to encourage their participation. We budgeted \$300,000 for that promotion.

Two concepts were included in the legislation to control health care cost inflation: network providers and peer review. Although mandatory components when the bill was drafted as a State-administered plan, the inclusion of these cost containment measures by insurers is now permissive. Originally, it was envisioned that agreements would be reached with a network of health care providers who would provide services for a certain cost and would receive only a portion of their payments for these services. The remainder of the payments would be held in reserve and returned at the end of each fiscal year in proportion to the plan's experience and resources available. Panels of peers would be developed to review the services and charges of physicians and hospitals and to deny payment and suspend providers if charges were excessive.

Employers who elect to provide the State-certified plan for their employees are required by the act to pay 50 percent of the premium attributable to the employee. They may pay more than this amount and may contribute toward dependent coverage, but are not required to do so by the act. To offset this initial cost of providing this coverage, the employer will receive a tax credit of \$15 a month for a 2-year period for each employee who participates in the plan. If the employer has no tax liability, the \$15 will be refundable to the employer or that amount which is the difference between the tax liability and the tax credit. If the plan can be offered at a monthly premium of \$60—which is not a sound and solid number in my view, but as it goes up 1½ percent a month—it is very hard to nail a number, but if that number were accurate and

the employer pays 50 percent of that amount, \$30 per month, he will receive back from the State one-half of his expense for providing the insurance. In other words, the first 2 years that the employer provides this coverage, the State will split the cost with him.

I am convinced that Oklahoma has enacted a program which will work. Initial actuarial studies support my belief that a low-cost, basic health benefits plan can be developed. I have faith that an elective program can work if the right product is marketed for the right price and if the incentives are there to the purchase of the product. Senate Bill 346 will enable us to create that product and has put in place incentives which will make it work. I would be happy to answer any questions you might have.

[Mr. Fisher's statement may be found in the appendix.]

Chairman ECKART. Thank you very much, Senator. Late last May when I had asked the staff to go find me a State that had experimented with creative approaches to the health care problem and they recommended Oklahoma. I did not know that the problems Oklahoma face were as serious as you described at the top of your remarks here. Your legislative initiative is a bit of a bold gamble. Perhaps we can learn some more from that when we get to some questions.

Let me come down to Commissioner Lyons, who I understand has to leave within about an hour or so, and I do not want to detain him from his appointed rounds.

I would advise each of our witnesses and, of course, those who are not witnesses have additional written submissions—that your prepared remarks will be made a part of the complete record in their entirety. Commissioner, please proceed as you see fit.

TESTIMONY OF DAVID LYONS, ACTING COMMISSIONER, IOWA DEPARTMENT OF INSURANCE

Mr. LYONS. Congressman, staff, State officials and small business leaders, it is a pleasure to be here today representing Iowa. I am also representing the National Association of Insurance Commissioners, a 54-member national regulatory body for State insurance operations.

I will strive to remember and abide by the three golden rules of testimony. First of all, for one's remarks to be immortal, they need not be eternal. Second, if I simply read from my prepared remarks which have been distributed to you, it will look like my staff did all the work and I am just reading from their material. Third, I will always assume that more time is necessary for people to point out the shortcomings of my presentation than for me to point out the positive points of my presentation. So, I will try and leave as much time for discussion as possible. Keeping these in mind, I would like to make a short set of remarks anyway.

My name is David Lyons, and I am with the State of Iowa. I am also a member of the National Association of Insurance Commissioners Task Force [NAIC] on Small Group Health Insurance. That brings us to the issue at hand today. What progress on regulatory and legislative activities on a model legislative format have been made, and do these activities and points of progress meet the re-

quirement that they be designed to ease the tremendous health insurance burdens placed on small businesses today?

There is a hue and cry today for assistance to small businesses for some relief from the current health insurance market practices which, to say the least, in many instances, are abusive. The National Association of Insurance Commissioners and its individual members have heard this cry and have responded, and many have responded quickly. States such as Oklahoma, who I think deserves specific recognition, have taken innovative efforts at the cutting edge of the problem. Other States, such as Connecticut, California, Iowa, have pushed forward on these programs, but that has not lessened the need to develop an overall model regulatory format that all States can take a look at, no matter the level of their resources or their level of expertise.

Today, you have received extensive materials describing the newly developed uniform model legislation designed by our association for adoption in the States to provide relief across the Nation. I will not reiterate the entire program. But instead, I would like to take a minute or two to highlight several of the watershed proposals this program is bringing forward.

Our activities as an association and as individual commissioners revolve around correcting abusive rating practices, improving continuity of coverage for both groups and members of small groups, assuring availability of coverage for all small businesses, regardless of employee health status, and development of a reinsurance pooling mechanism which will develop this program as viable for all employers, no matter what health issues face them, and all insurers, no matter what size they are.

The first step in reforming rating practices is to ensure that small business consumers thoroughly understand how their rates are being determined. The NAIC task force is imposing a requirement that insurers disclose the following information at the time of purchase.

First of all, the insurer's right to change rates and any factors, including the group's claim experience, health status, duration of coverage that could affect the group's rates. Second, the class or block of business the group would be placed into within the insurer's book of business. Third, the conditions that would affect the renewability of coverage. Disclosure of these factors should enable small businesses to make informed purchases of group coverage and to better understand how their rates may change at renewal. Additionally, it will warn them what issues will be brought up at renewal. Too many search for just the lowest coverage in their first year, and do not go back to determine how they are going to be affected in the second, third, and fourth years.

The second and most significant, I believe, step being taken by the task force is placing limitations on current rating practices. Single-year rate increases of 50 percent, 100 percent or 200 percent for small group employers have, in the past, not been unusual. But in the future, will not be tolerated. The task force is proposing a three-prong limit on rates. The three prongs—it is a multiple oversight approach we call the inside, outside, and overall restrictions.

First of all, within any class or block of business of a small group, rates would not vary and could not vary more than 25 percent from the midpoint for anyone.

Chairman ECKART. Within any class.

Mr. LYONS. Within any class. If you are in a class of business which includes XYZ Manufacturer's small employers, your rates—no matter what your health—could not be 25 percent higher than the midpoint of that class.

Second, for all classes of businesses, not just a particular one—the midpoint rate of any class could not be more than 20 percent higher than the lowest rated class of business. Therefore, if you are of one particular class of business, XYZ Manufacturers versus ABC Health Services, you could not differ by more than 20 percent.

Third, in any year, the maximum increase that an employer could receive would be equal to the change in the rate for new business—that is basically the loading for health costs and trends—plus 15 percent, based on your individual risks. Insurers would be permitted to apply to the insurance commissioner for a waiver of the 20 percent ban differentiating between classes, but that would have to be subject to specific review and approval by the commissioner, and therefore, would be subject to a much higher level of scrutiny than it presently is.

So, that is what we call our inside, outside, and overall protection system. As Oklahomans probably know better than anybody, a triple option is an effective tool.

Essentially in any year then, the maximum change in rate that could be attributed to a group's health status, claims, and experience or duration with the insurer would be 15 percent—far different from the 200 percents and 300 percents we have been seeing lately. Otherwise, the annual rate change would be based primarily on the change in rate for new business, which would reflect the trend in health care costs and utilization.

The new business rate was chosen as an index by the working group because insurers are heavily penalized if they cheat. If they raise it too much, they would be uncompetitive for new business because their new business rates would have to rise as well. If they keep it too low, they would be underpricing their entire class of business and would threaten their own solvency.

In addition, the task force is considering a requirement that each insurer keep on file for examination a detailed description, including all of its documentation, for the insurer's rating methodology and underwriting practices. In addition, each insurer would be required to file an annual actuarial certification that the insurer's rating methods are based on sound actuarial principles. We believe these requirements would help improve the ability of us, as State regulators, to monitor the rating practice of insurers and enforce the limits on rating practices described above.

As you probably know, many States do not regulate group health insurance. It is specifically done by experience. What we are trying to do is recognize the need for a high regulatory profile without tripling the size of regulatory staffs necessary and doubling the size of budgets. Putting the burden on the insurers to come forward with clear, concise actuarial information from uninvolved consultants

that we can review, I think, will go a long way toward curing the problems we see with low regulation in this area.

The third step taken by the task force is one designed to significantly limit the ability of insurers to terminate or nonrenew coverage. In addition to the thousands of complaints we, as regulators, receive relating to massive increases any particular year because of health status, we receive thousands of complaints that, the company just dropped me. The task force is proposing renewability provisions which would accomplish three basic reforms.

First, it would prohibit termination or nonrenewal by the insurer of individuals or dependents within a group. You take the group, you take the whole group. You do not carve out somebody with serious health issues.

Second, you prohibit the termination or nonrenewal of the insurer of groups within a class of business. You cannot move within a selected class of business you do and technically determine, I want you. I do not want you. I want you. I do not want you. What we are saying is, treat it as an entire class of business and allow them all to participate.

Third, it would permit termination of a class of business within the same rating group only upon notice to the groups and notice to the commissioner of that State and approval by the commissioner of that State. However, an insurer that cancels a class would be prohibited from starting business for a newsimilar class for a period of 5 years. You are either in or you are out—no in between.

We believe that these provisions would go a long way toward guaranteeing continuity of coverage for small businesses and their employees. Our goal is, once you are in the health insurance market, every effort must be taken to keep you in the health insurance market and not to let you drop back out.

Termination or nonrenewal of specific groups or individuals is going to, in the future, be generally prohibited. Further, the penalty for terminating an entire class, that is, 5 years out of the business, I think, will discourage termination, except in the most extreme cases where an insurer is unable to continue to provide coverage or is leaving the market altogether as a business judgment rule. We certainly do not want to enter into making business judgment decisions for the insurers.

I have also submitted some dramatic materials to you for your review and which will be part of the written comments on model legislation work on other important issues that will set the tone for regulation and legislation in the State level in the future.

Very important is a reinsurance pooling mechanism that most of the States will need to develop. This will, hopefully, allow all insurers to participate, no matter what size, because they can go to an established reinsurance pool to pass the risk into a larger pool of individuals. It will also allow the risks to be spread across a much larger spectrum. This will make an individual's health status—the health risks they face—an issue of little or no cost effect for their insurance. This is something we need to get to.

We also have a set of provisions which are known as take-all provisions. It will require insurers in the future to insure all eligible and dependents of an employee, not just those which a contract may wish to cover. It is a take all in the group.

Second, we have total continuation provisions which we are stating. If you continue coverage in any group status, you must continue coverage for the entire group, not just for selected individuals.

Chairman ECKART. You cannot cherry pick.

Mr. LYONS. You cannot cherry pick. You cannot cream the crop. The rest of the information, I think, is fairly well outlined in the materials I have submitted, and I know that you need to move along. I will save any additional remarks for responding to questions. But, I hope you can see that the National Association of Insurance Commissioners and its individual States are coming up with the type of model legislation—the type of model approach and the uniform application—that Congress needs to see and I think Congress needs to support. Thank you.

[Mr. Lyon's statement may be found in the appendix.]

Chairman ECKART. Commissioner, the answers are not always found inside the beltway of Washington. That is the purpose of coming out and listening to real people tell us what they can do so successfully at their level.

Mr. Brett Dickey from the actuary department in the Oklahoma State Insurance Department. Mr. Dickey, your complete statement will be made a part of the record, and you may proceed as you see fit.

TESTIMONY OF BRETT DICKEY, ACTUARY DEPARTMENT, OKLAHOMA STATE INSURANCE DEPARTMENT

Mr. DICKEY. Thank you. I would like to thank the subcommittee for allowing us the opportunity to appear before you today. I am here representing Gerald Grimes, who is the Oklahoma Insurance Commissioner. I am the director of the actuarial division of that department.

The insurance department's concern is not only whether or not coverage is available, but also the quality of the coverage that is being offered. Too often, poor coverage ends up being no coverage either through the liquidation of the insurer, collapse of a trust, or just the rise in the premium rates beyond the point of affordability.

Here in Oklahoma, our insurers have been making efforts to increase the availability of health insurance coverage. There have been several new products that have been developed by Oklahoma insurers to address the small business market.

One of these has been Blue Cross and Blue Shield of Oklahoma who has developed a basic program. This program offers a basic level of benefits. It is not intended to be a comprehensive major medical type program, in order to keep the premiums down and make it affordable for the part-time employees and the small business owners. It meets all Oklahoma mandates required by Oklahoma law, and it also includes such things as prenatal and maternity care, well baby care, and some mental health coverage also.

In the last few years, we have also been approving health insurance contracts which contain what we call a PPO rider. That is a preferred provider organization. These riders allow an insurer to choose from a list of doctors who have agreed to discount their services. This allows the insurance company to pass the savings to it in the form of claims submitted directly onto the insureds. It also

allows the insurer to carefully monitor the utilization of the health service and the health coverage that is being offered.

Our department has also been involved in the passage of several statutes designed to increase the availability of health insurance and also to protect the insured. Our group accident and health statutes were amended in the last legislative session to allow for employers in different industries to band together to provide—to purchase a group health-insurance policy. Previously, only employers in the same industry could receive a group health policy pursuant to this statute.

In 1988, Oklahoma passed a law which was written to protect employees in groups of 10 or more from losing their benefits when coverage was replaced. We were seeing many employers, due to the economic conditions in Oklahoma, canceling their group health insurance coverage and going for a cheaper or less costly plans. Unfortunately, many of the employees who had developed health problems, had preexisting conditions and were then excluded from this new plan. They were still employed, still on the payroll, still working, but had no health coverage at this point. Our no loss/no gain law was written to address that problem and to require a replacing insurer to pick up those individuals on any preexisting conditions and any deductibles that were met under a prior plan.

We have also passed a law in Oklahoma which requires a 30-day extension of coverage for employees whose insurance is terminated for any reason. That would include gross misconduct. This allows the employee or the individual an opportunity to find other coverage and gives them a 30-day period to do so. If an individual is totally disabled or under a plan of continuous surgical treatment, which would include maternity care, at the time that their insurance is terminated, they are required—the insurer is required to cover those individuals for at least 3 months for a basic program and up to 6 months for major medical coverage. That way, we do not have any individuals who have become totally disabled and are out of work, have their health insurance coverage ended. This applies to groups of less than 20. Our COBRA Federal legislation only applies to groups of 20 or more, therefore cutting out the small employers from receiving these very needed benefits. So, our law covers groups from 1 to 20. It would allow them to have that—to continue their coverage.

Our financial division has addressed the needs of the insured by prioritizing the admission of companies who are interested in writing health insurance in Oklahoma. We have taken a very active role in trying to encourage companies to write this type of coverage by encouraging these companies to apply for admission into the State of Oklahoma. We have had approximately 12 in the last year. We do have to balance that need with the realization that we do want financially solvent, strong companies to come in who can aggressively market that coverage. So, we have also taken that into consideration.

We have also recently employed a full-time market conduct examiner. His duty is to specifically go out and examine life and health insurers. He reviews such things as their marketing conduct, their underwriting activity and claims paying practices. This

is to ensure that no abuses are going on out there, abuses which have been especially prevalent in the small business market.

We have also attempted in the last legislative session to pass some legislation concerning MEWA's or Multiple Employer Welfare Arrangements. We have seen a need for some regulation over certain of these programs. There are some very good trust type programs out there right now. There are some that we feel have taken advantage of the lack of health insurance coverage. We have attempted to pass legislation to address this and to regulate these to a certain extent, realizing that there are ERISA exemptions for ERISA-type programs and VEBA's, which we do not intend to regulate. But, we are going to continue with that, and we do intend to bring that up in the next legislative session and try and get that passed.

We hope that the effect of our actions will be to increase the availability of health insurance in Oklahoma, without turning our back on the quality of coverage that is being offered. We have become very aware of the rising costs in the health insurance industry. I receive several phone calls a day from small business employers and employees who are having problems with their health insurance.

We have placed Oklahoma Health Insurers into liquidation in Oklahoma as a direct result of their involvement in group accident and health coverage. So, we do realize that due to the rising cost of that health insurance coverage, it is directly impacting on the insurers and their ability to stay solvent at this time.

We feel that medical inflation, a sluggish Oklahoma economy, and increased utilization of health care have all contributed to these rising costs on the insurance companies. We have seen insurers here in Oklahoma raise their rates on small business coverage every 6 months, and we have seen rates for an individual hit \$900 a month. You are not only affecting the indigent population here; you are also affecting the middle and upper middle classes. The rates are just not affordable.

As a result of this—as a result of the pressure on the insurance companies to increase their rates, we have seen many small companies turning away from traditional insurance to alternate methods of coverage. Such things as the trust and the MEWA's.

Without an authorized insurance company fully underwriting the coverage, there is no insurance department regulation and no guaranty fund protection in the event of the insolvency of these types of programs. Many times, the small business owner is rather naive about insurance and is not aware of what he is getting into and does not know that there is no State insurance department regulation of that plan, and they find that out after the plan quits paying the claims.

These are some of the problems that we have seen and some of the solutions that we have been involved in. We feel that these actions have increased the availability of the insurance coverage here in Oklahoma, without affecting the quality of the coverage that is being offered. That would be our testimony today, and I welcome any questions that you might have.

[Mr. Dickey's statement may be found in the appendix.]

Chairman ECKART. Thank you very much, Mr. Dickey.

Mr. Horkey, I understand that your State recently concluded the most comprehensive analysis, examination, exploration of what can be done. I guess it was just within the last week that you have completed those recommendations. Congress probably has much to learn from what you have—what you have examined. Representing the Oklahoma Council on Health Care Delivery, Mr. W.R. (Dick) Horkey, as vice chairman of that council. We will receive—I would like to point out to you—the entire council's report and see to it that it is distributed to the Congress, particularly to the appropriate health committees, the responsible jurisdictions. Please proceed as you see fit.

**TESTIMONY OF W.R. HORKEY, VICE PRESIDENT, HELMERICH
AND PAYNE, INC.**

Mr. HORKEY. Thank you, Mr. Chairman, and I would request also that you receive the statement of Mr. Phil Watson, on whose behalf I am appearing this morning.

Chairman ECKART. Without objection, that statement will made a part of the record as well.

Mr. HORKEY. Mr. Watson is our chief bureaucrat, I guess, in the State. He heads the largest department of the entire State and—

Chairman ECKART. Are you praising him or damning him in that reference?

Mr. HORKEY. I am praising him for his ability to administer it, and particularly in view of the mandated sort of things that Congressman Synar mentioned because now, Director Watson has to worry about fitting those mandates into his budget with the lack of funds Senator Fisher appropriated for him.

The Council on Health Care Delivery was a creation of the State and was composed of representatives of Government, of hospital administrators, physicians, business people, and insurers. It was well represented and spent some 2 years examining the situation and came up with varied recommendations. I would repeat emphasis on the statistics that Senator Fisher gave, many of which are included in Mr. Watson's statement, and ask that one particular reference in Mr. Watson's statement where he stated, further analysis of the data indicates that nearly 60 percent of the working uninsured, including their dependents, are employed by business establishments that employ less than 20 employees, be amended to point out that when he was speaking of working uninsured there, he was speaking only of those employed in private industry. But, that statistic does not hold true across the entire employed spectrum, but it excludes State employees.

I want also to emphasize this part of it which points out why—Chairman, you commented that Oklahoma must rank pretty high. Oklahoma ranks eighth in the Nation, in terms of numbers without health insurance. That is not the sort of statistic you are proud of being high. But, part of the reason is that according to Oklahoma Employment Security Commission data, nearly 41 percent of Oklahoma's nonagriculture and salary workers are employed in the retail and service industries. Typically, these are the industries that are on the lower end of the pay scale, and they also are the industries which are less likely to provide health benefits.

I point that out, along with another comment from Mr. Watson's statement, that, according to a study prepared by the National Health Care campaign in Washington, DC, it is only the families who earn more than 250 percent of the poverty level that when they begin to accumulate—or that begin to accumulate the disposable income required to contribute a portion of their premium costs. In my remarks for later in the morning, I make reference to a remark made by Dr. Louis Reinhardt of Princeton that probably only one-third of the employed uninsured can afford to purchase health insurance.

My emphasis on this point is that in the course of the study of the council, we were asked specifically to direct our attention to the working uninsured—the very group that Senator Fisher's bill was designed to cover. Our conclusion in the process of that study was, yes; we can provide coverage and yes, it will help, but it is not really getting to the majority of the people that we need to reach. It does not begin to reach the unemployed uninsured which nationwide, at least, are supposedly equal to the employed uninsured or underinsured.

That drove us in the direction that if we came in with a report that said, yes; we support Senator Fisher's bill. Yes; we need a risk pool for the medically uninsurable. We still were not getting at the core of the problem the entire mass of costs of health care. That the only way we were going to get there was to take a comprehensive look at the problem.

In terms of other States who have taken comprehensive looks at it, specifically, Arizona, Colorado, and Oregon, we opted for the Oregon-type study and solution, hopefully, and that directs itself in the area of studying what services are being rendered, what services need to be rendered, what service can afford to be rendered.

We recommended that the Medicaid Program be broadened. Again, another matter that I just read in this morning's paper, Oklahoma was said to rank 26th in the State of its health. I assume that that was a headline designed to be highly favorable to the State. Reading it a little closer, I noticed that there were 5 others tied for us at the 26th rank. It does not take many more ties above that to make us last. The article did say Alaska was last, but it may only have been 27th.

But, we were credited for ranking very highly in terms of the number of primary care physicians available in the State. We think this is core to a gate system, to a managed care system that properly controls access to the health-care system and gives us a better chance of managing it and controlling it.

Again, Oklahoma ranked low—and we think very near the bottom—in prenatal care. We have recognized this problem. We have amended our Medicaid regulations to include more people in prenatal care. Senator Fisher mentioned in his bill, prenatal care, well baby care as a requirement of whatever policy was being sold. We know that those are the dollars we can spend now that will save us the most dollars in the future.

Mandated benefits are one of the reasons that we have high costs, and all that we ask of those who mandate the benefits is that they recognize there is an immediate cost of those benefits. The mandates are, I believe, always well intentioned because down the

road, they are going to save us money. But, when you mandate those benefits, do not lose sight of the fact that that increases our immediate costs because budgetary problems for State and Medicaid causes problems for the insurance carriers who have sold the policy and had a period of time before they can adjust their premium to take care of that.

I will stop my remarks at this point and seek to answer on behalf of Mr. Watson any questions that are directed in the area of the State's participation in the council's report.

[Mr. Horkey's statement may be found in the appendix.]

Chairman ECKART. Thank you very much, Mr. Horkey. I think the State council has done a real service to the other 49 States. Sometimes, the toughest thing to do is to take a hard look at yourself in the mirror. By doing that, Oklahoma perhaps can serve as a little bit of a road map for the rest of the country.

Commissioner LYONS, let me begin with you. A number of years ago, we heard a lot of discussion about liability insurance. That was the big crisis a few years ago. Now, as I travel my district and conduct—as I said, this is now the fifth in a series of hearings on this question, trying to draw from the States the strengths of how they reacted to their problems—have we moved past the question of liability? Is your assessment that the health insurance question is the dominant one in the spotlight?

Mr. LYONS. Yes; I believe as high as property, casualty, and liability issues were the focus of the 1980's, I believe health care will be the issue and the focus of the 1990's. If you look at poll situations—just looking at individual gubernatorial races—I like to follow as many issues as possible, I find that health care and health-care insurance are ranking second, third, and fourth, basically, throughout the States; whereas liability insurance itself never ranked in a gubernatorial election above sixth, seventh, or eighth. So, I think you are seeing a tremendous increase in the concerns and the activism relating to health care.

Chairman ECKART. Commissioner, you raise the question of politics. A number of the questions—issues in your model legislation are politically tough ones. The Senator probably knows better than many what that means. Can you handicap for me what you think how likely passage of such a comprehensive suggestion as the model would be. Give me your best guess of what is likely to happen. Gaze into a crystal ball for me as to what is likely to happen with your model suggestions.

Mr. LYONS. First of all, I would say every time I go to the track, I visit the betting window more often than the collection window, so you are going to have to take this with a grain of salt. I would say with the pressure, there are three things involved to make change comprehensive across the Nation through model legislation.

The first is a very strong and pervasive public attitude. No doubt we have that attitude right now. It is not going to disappear for the next 5 years. It is not going to disappear for the next 10 years. People will have learned from this crisis and they will continue to exert themselves for further increased protections. So, we have got the first leg.

The second leg is is we need cooperation among the States, as one of the weak link theory. Certainly, it is wonderful if 10 States can pass it, but that leaves 40 that do not.

Chairman ECKART. Which means pressure comes right back to us.

Mr. LYONS. Right; people want Federal regulations so all States have to have minimum standards. There is, I would say, the likelihood that every State will have undertaken this type of program in one form or another within the next 3 years. We have already seen a third of the States attempting to go it alone. We have seen Oklahoma. We have seen a number of other States, such as Connecticut, California—very innovative programs, very costly as well, for the State to try to develop this expertise and this programming themselves. That is why the national associations and that is why the national experts have to develop some centralized focus and some centralized resources that States that draw upon. So, we have got this type of support.

Most model legislation says, nobody will adopt it. We have already got a third of the States involved in the process. Another third have all had bills introduced that they expect to pass in the next 12 months, such as Iowa and a number of other States. The remainder of them are saying, help. We need a model piece of legislation. We set our goal of having this model legislation done in 2 years. There was a vote of 50 to nothing at the round table conference of the commissioners that said, great, you will have it done in one year. So, it shows you that the States are committed.

The third is that you always have to realize it has to go through State legislatures, in many circumstances, or through State regulatory processes, which are subject to lobbying by the insurance industry.

I do not want to make any bones about this. The insurance industry is as much concerned about curing this problem as we are. They realize that in 5 years, if you are a health insurance company, you are going to be an administrator, not an insurer. You are going to be out of the market. It is not going to exist any more. They are committed to assisting us. In fact, half of the materials that are very forward thinking, that are really compressing these rates increases, et cetera, that you have heard me talk about today, the industry really gets credit for because their experts went to work and said, I know this is not normal for us to figure out how to restrict ourselves, but how are we going to save ourselves from ourselves? So, we have tremendous insurance industry support as well. If I am going to handicap, I would say by 1995, every State will have some form of this.

Chairman ECKART. Commissioner, I understand you have an airplane to catch.

Mr. LYONS. Yes.

Chairman ECKART. Which is not dissimilar for me, but I have 4 more hours, so I will excuse you.

Mr. LYONS. I would like to make one other comment.

Chairman ECKART. Yes, sir.

Mr. LYONS. I think if Congress—we sat down as commissioners and tried to determine really what the key core problem was and where everybody needs to focus—you have to have a central

focus—what are you trying to get at and what pattern are you trying to change—and we came up with a specific statement that I think is good for Congress to know that we are following and for Congress to keep in mind, and that is, the insurance market's focus has shifted away from what it was in the past—from long-term sharing of risk across a relatively large number of groups. That is where insurance came from.

But in the past 10 years, it has shifted toward providing a low, short-term price to select groups for a quarterly bottom line outcome. That cannot continue. Every effort we make on the regulatory, on the legislative or on the national level needs to be geared toward changing the focus of the market back toward long-term stability, long-term service to consumers and long-term recognition of future consumer needs and having them ready when the consumers want them, so they do not have to come to State legislatures and they do not have to come to Congress to get them from the industry. Thank you.

Chairman ECKART. Thank you, Commissioner. God speed on your return to Iowa.

Senator FISHER, let me—if we could pass the microphone down. A number of matters of controversy clearly on the direction you have taken. It was not but 20 or so years ago, Senator, that I remember in my community you had a local committee which decided who was going to get on kidney dialysis. That was a decision of life and death that neighbors had to make about friends—people that they worshipped with, people whose kids their kids went to school with. To what level do you consider rationing? Oregon has experimented with this in some degree as they have specifically said, we are not going to pay for certain procedures, certain transplants—too expensive. We want to talk—we want to focus on women, infants, and children, well baby, and prenatal care. What was that debate like for you here?

Mr. FISHER. Certainly, those issues were discussed in some great detail, as Mr. Horkey and I spoke in several meetings together and had many discussions over what can we do, and that brought the bare bones type coverage to the table. There had to be important decisions made.

Historically, we concluded that at one time, and I can remember not specifically the year, but some 20 or 30—I would say closer to 30 years ago—that when the notion of a very innovative thing called maternity care was introduced to the insurance policy. That was not excludable. It was included in the insurance policy. You could not take it out. If you were 60 years old, you had maternity care coverage. It was a beautiful new bell or whistle added to basic health benefits. The entire insurance industry ran to that position because they were at a competitive disadvantage without it. The insurance industry also started adding new bells and new whistles and new bells and new whistles, until we had a policy so wide that nobody could pay for it.

Now, what we seek to do in my bill, is to structure what the minimum basic health benefit should be, declaring certain exclusions. For instance, transplants will have x available, and prenatal care, as Mr. Horkey suggested, and as we all know who deal with this, that is the best possible dollar that you can spend for long-term

saving. We do not mandate that it fit a structured policy. We say it must be this minimum.

Chairman ECKART. Did you not run headlong into the mental health advocates—

Mr. FISHER. Yes.

Chairman ECKART. When I was in the Ohio State legislature for 6 years, and a member of the insurance committee. The big fight was mandated mental-health coverage. The following year, it was coverage for alcohol-outpatient treatment. Each year, from a public policy perspective, we had desirable goals made a part of mandatory coverage. How did you reconcile that politically at your State level?

Mr. FISHER. We just got very tough about what we were going to do. We were lobbied from every angle for—you have got to include my group. You have got to include my group. Frankly, there is more groups in there, perhaps, than should be right now. But, it is a bare bones deal. I can tell you, it was not easy. The pressures are immense, as you have suggested. Every group comes to the table to insert their deal, but we had a very hard working and very tough committee.

Chairman ECKART. You have worked hard to keep a narrow framework for of your bill, as I have grown to understand it now. You have my sympathies in that regard. You have become instant experts, and boy, it can be tough. But, it is based on incentives. If incentives do not work, is the next step mandates?

Mr. FISHER. There is no assurance that this bill will work. While I hope it does, while I believe it can, still at issue is whether the insurance industry comes to the party.

Chairman ECKART. Yes.

Mr. FISHER. We have no clue at this moment. The board is in the process of just being set up. The first organizational meeting has not yet been held. It is not clear whether they will come to the party or not. But, you must understand that we are not telling them what price to charge. We do not feel like we can do that. But if, in fact, considering the pressures that we had on us that it was not Government's job to get in the insurance business as we had sort of—the position we had started out to go—is that we were going to get the State into the insurance—and help regulate this thing from a public insurance company.

The insurance industry told us, it is not your place. You are out of place. You do not know anything about it. It is a debacle and do not do that. We did not, so we have now structured a program—not necessarily at their behest, but one that found our State in a financial condition that this was the best first step to see if, in fact, if it is not our job, then it is the insurance industry's job to do it.

Chairman ECKART. As someone who has been through this, let me ask you quickly about two of Mr. Lyons' ideas. First, unrestricted dropping.

Mr. FISHER. I do not have an opinion as I sit here.

Chairman ECKART. The second question would be rate restrictions—the so-called caps above the midpoints.

Mr. FISHER. All that focus is—goes back to one thing—is that we must have, as Commissioner Lyons suggested, the whole theory of insurance is that we all pool our money for the long-term protec-

tion of those who are unfortunate. That is the theory of insurance, and it can no longer have a situation where we try to cream off and cherry pick the low, the under-aged, the young and healthy, and try to isolate them into the group and exclude all others. We cannot go on in that fashion. That is at the root of both questions.

Chairman ECKART. Mr. Horkey, if I can get the microphone passed to you, quickly. Would you respond to my earlier question about your consideration of the so-called Oregon-type solution focusing on rationing and limiting, picking priorities and saying, we want to emphasize prenatal care, but we do not want to spend a whole lot of money on very expensive transplants, for instance. How did your council settle those disputes?

Mr. HORKEY. Our council did not settle any disputes. Our council hopefully created the environment within which forums can take place to begin to resolve these issues. We are very much in admiration of what Oregon did over a 2- to 3-year period of holding public forums throughout the State, getting input from all of the citizens. Not waiting for that, another group that I am affiliated with here in Tulsa, is underway now with a major forum seminar on the entire issue of rationing involving the ministerial group, the philosophers, anyone and everyone who wishes input, the medical community, hoping to stimulate an atmosphere in which the resolutions will be made.

The concept you, Congressman Synar, Senator Fisher, may not like because the resolution of that is, it is the politicians who are going to be forced to make that hard decision. You will allocate the money for the procedures, or you will not. Ultimately, that is where it is coming down, and as elected representatives of the people, maybe that is where it belongs in preference to an appointed czar who makes arbitrarily those decisions and enforces them.

I would respond personally to the question that you asked Senator Fisher about where do we go if the voluntary system does not work——

Chairman ECKART. That was my next question.

Mr. HORKEY. All right; if you subscribe to the Oregon system, then given a period of time to voluntarily do it, if you do not do it, you are mandated. Senator Fisher and I personally have discussed this, and I think we both are in that same position. That is not an official political posture that he is taking, but that is the ultimate answer to it. If the voluntary system does not work, those of us who are extremely dedicated to free enterprise in the business system feel we should be given a chance to try to make it work before it is mandated.

Let me depart from a question that you have asked me and not leave something resting that was implied in the answer that Commissioner Lyons gave to the question that you asked him about liability no longer the number one issue, and he gave you what I would categorize as a very generic answer about liability policies, including products liability, and directors, and officers insurance. Yes; those policies are now much more available than they were in a period of time. But, you cannot disassociate the whole question of medical malpractice liability coverage from medical care costs. It is an integral and great part of it, and that part is not solved.

Chairman ECKART. We have heard that before. Senator, you were either waving at me or a fly buzzed in front of you. Did you want to respond to something Mr. Horkey said, particularly as he attempted to characterize your position, being very sensitive to who speaks for whom.

Mr. FISHER. No.

Chairman ECKART. Then, Mr. Dickey, I am going to come to you for a question.

Mr. FISHER. I would like to say one thing. For those of us who cling to the precious thing called a free-enterprise system. It is interesting that in the health care industry and in our health system in the United States, free enterprise does not work. As a matter of fact, it is just the opposite. It is interesting, but if free enterprise worked, it would say, the more hospital beds you have, the cheaper the price. The truth is, the more hospital beds you have, the higher the price. It is a complete opposite reaction within a free-enterprise system. It says that the more we are on the cutting edge and at the precipice of a technological explosion regarding medical technology.

Interestingly, hospitals buy gadget machine A—and I do not want to call it gadget, but it is a very high-dollar piece of equipment. All competing hospitals in that market must buy the same machine in order to be competitive.

At some point, while this matter that your subcommittee has chosen to deal with is a virtual Niagara of problems, it is served by so many tributaries that I do not know how we cut them off. But, one is to keep in mind that there is a—that the health care delivery systems are very competitive as well, seeking to be the number-one provider. Sometimes, that flies in the face of cheap health care.

Chairman ECKART. Thank you, Senator. Mr. Dickey, you mentioned in your testimony a 1988 law written to protect smaller groups from losing their benefits when the coverage was replaced by another carrier. Has the law succeeded in preventing gaps in coverage?

Mr. DICKEY. To a certain extent. There have been problems with the actual implementation of the wording of the law.

Chairman ECKART. We are going to be receiving some testimony from the next panel that suggests that it is not as effective as some small businesses here in this State would like. Do you concur or not that it might be helpful, but perhaps does not go as far, or—

Mr. DICKEY. I think that the effect of the law—it is a form of a mandated benefit. I am sure that it increased the cost of the health care coverage. But, I think that with the individuals that it was protecting, that benefit far outweighed the cost that was incurred on this. We were having numerous inquiries, complaints concerning changes in group health coverage, leaving out the people who needed the health-care coverage the most, and I think that is what the bill was designed to address.

Chairman ECKART. In a word—the State Insurance Department, is it a cabinet agency?

Mr. DICKEY. The Insurance Commissioner is an elected official.

Chairman ECKART. It is an elected—statewide elected official?

Mr. DICKEY. Yes.

Chairman ECKART. That is one of the interesting things—Senator, perhaps you will be interested in this—that we want to take a

look at next is, are there differences in the way the crisis is being met, depending upon whether the insurance office is elected or appointed within a State office. My colleague from Oklahoma.

Mr. SYNAR. Thank you, Dennis. I want to first of all start by thanking the whole panel for being here. I think it has been very helpful this morning. I just have a few questions to add on to what Dennis said. Ted, this number, 636,000 Oklahomans do not have medical insurance. That is a devastating number.

Mr. FISHER. That is nonelderly also.

Mr. SYNAR. That is nonelderly. So, if you threw elderly in there, that number could be——

Mr. FISHER. Assuming elderly are covered by Medicare, so there are some gaps certainly in Medicare as well. But, I think that is——

Mr. SYNAR. But, if we start with a 636,000 number as uninsured and we add on top of that underinsured, do you have any kind of a number where we would be approaching?

Mr. FISHER. No; I do not. That is—those numbers—and I would yield to Dick on this, but I think those are with zero coverage, does not anticipate or take into account underinsured.

Mr. SYNAR. Would I be exaggerating if I said that the number of uninsured, plus the underinsured in Oklahoma may be approaching the number of 30-35 percent? Dick?

Mr. HORKEY. I have no basis for a specific answer——

Mr. SYNAR. But, we know——

Mr. HORKEY. It is just a gut feel.

Mr. SYNAR. But, we know that better than 25 percent have no health insurance?

Mr. HORKEY. Yes.

Mr. SYNAR. OK. Now, when you said, Ted, that this was the number, what percentage of these medically uninsured do you expect to be eligible under the plan you talked about?

Mr. FISHER. Roughly 400,000 people and their dependents.

Mr. SYNAR. They would fit that eligibility requirement of 24 weeks.

Mr. FISHER. They are employed by small business. Interestingly, one of the reasons we took off and did it differently than Oregon where they said 25 employees or less in Oregon can only play in their scenario. We found that—I believe Dick spoke to this—but, we determined through our research that well over 90 percent of the employed uninsured work in businesses of 25 or less, so it did not make a lot of sense to exclude—just let everybody come in. I mean, for instance, there is one business in Oklahoma City that has 600 employees, and they do not have any health insurance—none. I understand they are represented by a union. I do not think I would want to belong to that union. But, at any rate, that is sort of an interesting.

Mr. SYNAR. That was my next question to you, the bill that you passed has been in effect for a year?

Mr. FISHER. No; it has only passed the last day of May.

Mr. SYNAR. OK, so we really——

Mr. FISHER. It is only 2 months old.

Mr. SYNAR. OK. The question I was going to ask you is how many companies do you expect to sign up on the plan? Did you do any studies to see what kind of interest level there was?

Mr. FISHER. The interest level is high, but we know full well that if, in fact, and this is a strange phenomenon in this business, if we gave it away, everybody would not participate. If you charge \$5 a month for it, everyone—you are going to have a considerable drop-off on the—in the amount of people that will participate. That was spoken to earlier that people opt for just a few pennies more, I do not need that. So, it is particularly in the young and those who deem themselves immortal. Health insurance is not a big deal until you are like those of us who have some age on us.

Chairman ECKART. With gray hair.

Mr. FISHER. Being rather long of tooth personally, I understand that. But at any rate, I think, at one time, Dick and I had this conversation, what do we hope the participation will be? I have made the statement that if we could get 5,000 people insured the first year under this, it would not be a disappointment to me. Even given the very large numbers. But even the first year, if we could get 5,000, I would not be disappointed, because I think it does take some time to introduce such a notion, to make it work, to sell the employer.

Second, in Oklahoma, we have been on our bellies economically. But, employers are more fully understanding that employees—good employees will jump to a job with benefits. Yet, they, in that particular job, cannot afford the benefits. We think as our economy heats back up and turns around—as there have been some indications that it is coming back—employers still value a good employee. We hope that that, in and of itself, will push them to seek this coverage.

Mr. SYNAR. One final question. Brett, I would like to know, what is the average percentage increase in group-health insurance rates in Oklahoma last year?

Mr. DICKEY. I do not have any figures on that. We do not approve health insurance rates in the State of Oklahoma. From my personal experience and seeing, we do request that companies file their rate increases with our departments. We will have knowledge of that, and we do keep that on file. I would say 20-25 percent on an average.

Chairman ECKART. Will my colleague yield on that point?

Mr. SYNAR. Sure.

Chairman ECKART. You do not have a file on review. What is your position on health insurance? Is it just simply filing?

Mr. DICKEY. On the rates?

Chairman ECKART. Yes.

Mr. DICKEY. For the group-health insurance, there is no provision on filing—or approval of those rates.

Mr. SYNAR. So, are you telling us that those statistics are not available?

Mr. DICKEY. We have not promulgated them at the Insurance Department and I have not seen the statistics.

Mr. SYNAR. You do promulgate them?

Mr. DICKEY. No; we do not.

Mr. SYNAR. Is there anywhere we can find those kind of numbers?

Mr. DICKEY. I have not seen them.

Mr. SYNAR. Mr. Horkey.

Mr. HORKEY. This is Mr. Watson's report, not mine. In 1989, employer-based insurance premiums increased 20.4 percent. Premiums forecast to increase 23 percent in 1990.

Mr. SYNAR. Now, how did you accumulate those numbers? I mean, where are those numbers from?

Mr. HORKEY. They were accumulated by Mr. Watson. I do not know from what source. I am taking them from his statement.

Mr. SYNAR. Mr. Chairman, I would like to leave the record open. Maybe we can find out that that may be an important statistic to find so we can see the growth of the problem and how it is, and we will work with Mr. Watson.

Chairman ECKART. Without objection, Mr. Watson's entire statement will be made part of the record.

Mr. SYNAR. Again, thank the three of you. I think it has been very insightful what you have told us this morning.

Chairman ECKART. I, too, thank the panel. I am delighted to have the chance to come here and to sample some testimony first hand because I think—Dick, I think you are moving off to the cutting edge. Senator, maybe if we can clone you and introduce you in about 49 other States, you might be very helpful in helping them address their problems. This first panel is excused.

I would like to, without objection, include in the record at this point statements from the Health Insurance Association of America and a statement from Mr. Joseph Ellis, an insurance broker who has submitted lengthy testimony as well.

[The statements referred to above may be found in the appendix.]

Chairman ECKART. For our next panel I would like to call forward, Mrs. Juli Greer, owner, with her husband of a small family-owned business in Tulsa.

Mrs. Joan Frame, owner of Frame Lumber Company, a small business in Checotah—thank you, Michael. Boy, I am glad I heard that whisper because it was not going to come out like Checotah, Oklahoma, which has had its share of difficulties with providing health insurance for its employees.

Mr. Jerry Hunt, owner of Employer Medical Care Locators, based in Broken Arrow, Oklahoma, a sign that I did see on the interstate driving over here from the airport. Mr. Hunt is an insurance broker who helps find health insurance coverage mostly for small businesses who are having trouble finding coverage.

Mr. Gerry Rothlein, Jr., executive vice president of First National Bank, past chairman of the Tulsa Program for Affordable Health Care and current chairman of the Health Care Delivery Task Force of the Tulsa Chamber of Commerce. Gerry, we want to thank you for being here with us on such short notice, filling in for one of our other witnesses. I particularly look forward to your testimony and to comparing it with what the Greater Cleveland Growth Association—that is what we call our Chamber of Commerce in Cleveland—what they have done.

Mr. Ronald F. King, senior vice president, Blue Cross and Blue Shield of Oklahoma. Clearly, you have probably been involved in

most everything we have heard about to date. Mr. King, we welcome you.

Ms. Greer, I understand this is your first time you have had a chance to do something like this?

Ms. GREER. Yes.

Chairman ECKART. Do not be afraid. We do not issue indictments. We are here to receive the commentary that you may have to offer. All too often, Mrs. Greer, what Congress overlooks are the real problems of real people. That is the purpose of us coming out beyond Washington and getting a chance to visit with folks like you. Our staff has reviewed some of your comments and tells me that it is the kind of story that is probably replicated in many other circumstances. So, Mrs. Greer, I will advise that your complete written statement will be made part of the record, and you may proceed as you see fit.

TESTIMONY OF JULI GREER, TULSA, OK

Ms. GREER. Thank you. I was asked to speak today about my experience in 1988 with an HMO.

Mr. SYNAR. Pull that microphone a little bit closer.

Chairman ECKART. A little closer there. There you go.

Ms. GREER. Is that all right?

Mr. SYNAR. Why do not you pull your chair up a little bit and get as close as you can. There you go.

Chairman ECKART. After a couple of sentences, you will forget you are talking to TV cameras and radio stations and all that sort of stuff.

Ms. GREER. I was not thinking of that. OK. I was asked to speak today about an experience I had in 1988 with an HMO insurance company, Health Accord of Oklahoma.

My husband, Gordon and I, are both employed by a small family-owned business in Tulsa. As the owner and all the other employees had group health insurance coverage through their spouses, who were employed elsewhere, my husband and I were the only employees without group coverage. In 1987, we responded to advertisements from the Metropolitan Tulsa Chamber of Commerce and subsequently enrolled in the group-health insurance coverage with Health Accord of Oklahoma. Although we were required to change doctors, we were happy with our selection. Our coverage with Health Accord was effective July—excuse me—August 1, 1987 to August 1, 1988.

In December 1987 when our new doctor confirmed my pregnancy and agreed to deliver the child, we were very thankful for our coverage with Health Accord. The baby's due date was July 26, 1988. In compliance with company requirements, we obtained membership cards effective August 1, 1987, for myself, my husband, and our three children and for Baby Greer, effective July 1, 1988.

On February 4, 1988, Health Accord sent a letter notifying all subscribers of their intent to dissolve their corporation. This, of course, was a great concern for my husband and myself. As time passed, we were advised by telephone that our family would be covered during the policy dates of August 1, 1987 to August 1, 1988. When an official of Health Accord was questioned as what would

happen if our baby was not born before August 1, he suggested we ask our doctor to induce labor prior to policy expiration, since my due date was close to policy expiration.

By letter dated March 31, Health Accord advised all members that the group care contract with Health Accord held by our employer would terminate on May 31. On the same date of March 31, Health Accord sent letters to each doctor or provider stating that Health Accord's responsibility for all benefit coverage for their members would terminate on May 31 and that all referrals for treatment or services extending past May 31 would not be approved. That letter mentioned that BlueLincs would assume responsibility for some of Health Accord's employer groups effective June 1. It was later learned that our group was excluded from BlueLincs' assumption.

On April 27, 1988, Health Accord sent letters to their physician providers stating that instead of the standard 75 percent paid on their provider claim, the plan had decided to set reimbursement on all claims submitted for services between April 1, 1988 until plan closing on May 31 at 27 percent of the fee schedule. Dr. Gray was very supportive, assuring us he would deliver the baby regardless of what fee was paid and expressed his extreme concern for me, as well as the baby. Due to continued stress regarding this situation, I was continually losing weight, rather than gaining weight.

Because of conflicting information from different sources, we were constantly kept in a state of confusion due to the uncertainty of whether or not our baby's birth would be covered. My health declined, and I was very worried about my baby's well being.

In response to a letter from PacifiCare of Oklahoma dated May 14, 1988, we applied for and were subsequently accepted for enrollment in their HMO. At that point, there was still a strong indication that I would have to change doctors and hospitals, which added to my stress, since I was in the last trimester of my pregnancy.

On June 28, Health Accord sent a letter to their pregnant members setting out various qualifications for continued coverage after May 31. This included a pregnancy certification form to be completed by the physician and a pregnancy enrollment form to be completed by the patient, for return by July 8. This letter set out exclusions indicating it covers only the member and specifically excludes all coverage for newborn. Because of this exclusion, I gave Health Accord the information they requested, but did not sign the form agreeing to their conditions.

I then contacted the Oklahoma Health Planning Commission, who had intervened and was working with Health Accord. They were unaware of the newborn exclusion, and at their request, I furnished them a copy.

Shortly afterwards, I was assured by PacifiCare that no change of doctor or hospital would be required for the baby's birth and that newborn coverage would be provided.

This ordeal ended approximately 2 to 3 weeks prior to our daughter's birth on July 22, 1988. We were very happy to resolve this matter; however, it did cause a great deal of undue stress and trauma during the last trimester of my pregnancy. I know there are many others who experienced similar problems.

I wish to thank Mr. John Ellis, our agent; Ms. Sandra Downie of the Metropolitan Tulsa Chamber of Commerce; Ms. Jimmie Hollister of PacifiCare, who were very helpful and considerate throughout this situation.

Although we are grateful for our current family health insurance coverage, the cost is nearly \$300 per month, based on our age group of 18 through 39. I am extremely concerned because of the increase in premiums at 9-year intervals, with similar insurance in the 50-64 age bracket costing at least double the premiums of the 18-39 age bracket. In comparison to large health-insurance groups, such as the U.S. Government, which charges a set fee for self only or family coverage, regardless of age, there appears to be a definite age discrimination on premiums for health insurance offered to older employees of small businesses.

Also, there seems to be another unfair difference between large groups and small groups in that coinsurance factors appear to be much larger for small groups. My suggestion is to allow entrepreneurs and small businesses to obtain health insurance coverage with fees charged and services provided comparable to those of Government contracts and large companies. By utilizing the conglomerate concept in providing affordable health insurance coverage to a large group of widely diversified companies, this would reduce flagrant abuse of welfare claims for medical assistance.

I appreciate the opportunity to present my testimony regarding our traumatic ordeal. It is hoped the issues discussed today will eventually help eliminate discrimination and provide more affordable health insurance coverage for small businesses in Oklahoma and throughout the United States.

[Ms. Greer's statement may be found in the appendix.]

Chairman ECKART. Ms. Greer, I am terribly impressed with one thing. The tenacity with that you exhibited in pursuing the veritable bouncing ping-pong ball of trying to obtain coverage while, at the same time, you were trying to deal with the family, a small business, and your pregnancy. I guess the sad part of your commentary is that I am afraid many folks would have probably just given up when they got that initial notice, and heaven only knows what would have happened. But, I think your tenacity was a good testimony as to the end result. Mrs. Joan Frame.

TESTIMONY OF JOAN FRAME, CHECOTAH, OK

Ms. FRAME. Congressman and distinguished panel members.

Chairman ECKART. Get the mike a little closer to you, Ms. Frame. Thank you.

Ms. FRAME. I appreciate this invitation to appear on this panel and to represent other small business people faced with this serious problem.

I live in Checotah, a town of approximately 4,000 people located near Lake Eufaula. It consists of approximately 115 small businesses and two small factories. The factories employ 165 people and offer insurance benefits.

This leaves approximately 113 small businesses with a total of approximately 598 employees. Of these, only 17 businesses with 236 employees offer health-care programs. This means approximately

362 will have no insurance because they cannot afford it. Multiply this times the thousands of small towns across the Nation, and you will see the stark reality of the situation.

The majority of these small businesses are in no way able to afford the heavy burden of this insurance overhead and are struggling just to maintain their businesses and to make a profit. You will note that these businesses who cannot afford health insurance plans employ approximately 90 percent of our workers in Checotah.

We are a family-owned business in the third generation of operation, being in the same location for 40 years. We employ an average of 12 people, 5 of these being family members. We started a health insurance program with Blue Cross and Blue Shield in the 1950's with the company paying all of the employees' premiums. Business conditions were good and health care was cheaper, so we could afford to offer insurance to the employees. Then, drastic changes occurred in health-care costs and insurance premiums, coupled with bad economic conditions in Oklahoma. These factors forced us to change our policy on offering health-care coverage.

We were with Blue Cross and Blue Shield approximately 30 years until November 1988 when they had a drastic premium rate increase. We had 11 employees on the group with a \$500 deductible. The only way we could have stayed with them was to go on a \$1,000 deductible plan, which was not feasible or affordable to the group. We shopped and compared extensively among the insurance companies available to us. In November 1988, the decision was made to go with Oklahoma Lumbermens' Association insurance health program. The premium was less and more benefits and \$200 deductible. The total amount of the premium was \$1,076 per month, a saving of 28 percent for the company, a figure that we felt we could live with. Then in May 1989, 5 months after being on the program, we were notified of an increase of \$578 a month, or 53 percent.

We are now facing a situation of some of our employees retiring soon, and we are considering dropping the whole program as such because of these difficult and expensive problems.

Small businesses and individuals are at such a disadvantage because they cannot compete with larger companies in getting smaller premiums and have no concerted lobbying for their interests.

I sincerely hope the interested parties here with legislative powers will take a genuine, sincere interest and concern for the people that are really so depending on them for some help. It seems health care has become so out of proportion that the Government must now step in with some kind of working plan. Thank you.

[Ms. Frame's statement may be found in the appendix.]

Chairman ECKART. Thank you very much, Mrs. Frame. Mr. Jerry Hunt.

TESTIMONY OF JERRY HUNT, EMPLOYER MEDICAL CARE LOCATORS, BROKEN ARROW, OK

Mr. HUNT. Congressman, that was not my sign you saw coming in.

Chairman ECKART. Oh.

Mr. HUNT. I got more than I can say grace over. I am not looking for more business. I am trying to take care of the ones I got.

Anyway, thank you, Congressman Eckart, for the opportunity to share my information on the health insurance crisis with small businesses and individuals. I have been trying for years to get someone to listen to the real problems facing the public on health-care access.

The leadership in health care look at numbers. I look at faces. I no longer can help people get insurance. My job is helping people stay insured—to keep them from losing their life and life savings. My days are filled with frustration and heart-wrenching stories. I am tired. I want something done. In Mark 5:9, Jesus was attempting to heal the crazy man. When Jesus asked for the name, the answer came. My name is Legion for we are many. There is too many evils in the health insurance business nowadays.

I have been at this business 30 years. A 63-year-old woman called me recently. This is only one of countless stories. She thought she had health insurance on her husband's job. But, the employer could not keep up with the rates, the requirements, the regulations—the three rotten R's. So then, there was none. She thought she had cancer, but was afraid to go find out the truth. I encouraged her to go, to create the debt, if she could create the debt, and save her life. It turns out she did not have cancer, but the battery of tests cost her \$3,000.

I believe—let me make one other statement. Most things I have heard here today has been a patchwork system. When you get a patchwork—what do they call it. It is a crazy quilt. That is what we are getting. I believe that most Americans understand that the primary purpose of the Government is to serve and protect its people. When a problem exists which cannot be solved by private enterprise, it is the Government's responsibility to take charge and to solve that problem. The medical meltdown has come to that point.

I believe the self-serving components of the health delivery system are out of control. They do not have the power to stop the impending destruction. That health insurance has become the domain of only the healthy and the wealthy. That politics and special interest groups now dominate the elected representatives of the people.

I believe that the cosmetic attempts to control the use of medical access has created discrimination against the working wounded, the self-employed, the individuals and most businesses with less than 100 employees. I believe that the medieval mentality of the health insurance industry underwriting practices has created a narrow band of acceptable prospects. That rating procedures that pit the old against the young, occupation against occupation, are unjust and unrealistic. That the right to pull out of a State a policy block of business is nothing but white collar fraud that dumps the uninsurable back on the streets with nowhere to go.

Recent Government attempts to create fair play in discrimination have been damaging to small employers. Let me say that again. Recent Government attempts to create fair play in discrimination have been damaging to small employers—not to unfair in-

insurance practices. COBRA was a wonderful idea. But if an employer wants to change carriers, he must include the COBRA's in his census, and the problem cases always stay on. The end result is the present employees must suffer, along with the company.

Most insurance carriers will not quote rates when the percent of the employees over age 50 exceed 20 percent. They will not quote.

Chairman ECKART. They will not even quote.

Mr. HUNT. They will not quote. Another damaging practice for loyal workers. The initial purpose of group insurance was a tax benefit to loyal employees. When did it all go wrong? Is it any wonder that small employers, and soon, all employers will dismantle their health insurance program. So, who killed the golden goose?

We all pay for health care now, even if we do not have insurance, even if we do not have a claim. Here is how. If you have insurance, the carriers, the providers all must make a profit. They have got to make a profit. Claims and inflation will increase those rates. When hospitals and doctors treat people who cannot pay or who they must discount because of contractual arrangements, they ship the loss to the payers also. When Government agencies pay for welfare and indigent care, then taxes are used to pay, and this is shifted also to the payers. We are all ducks on the pond, and the ripples hit us all.

Now, here is the choices that I believe that may be possible. Choice A is Government takes full responsibility to coordinate and implement a national health access program. Now, I did not say a national health care—I said access program, and hopefully not to be influenced by partisan politics and lobbyists. Choice B is Government expands the Medicare Part A to those age 50-plus on a voluntary basis. Premiums on a earnings formula. Why is age 65 a magic number? Choice C, Government gets completely out of the health insurance business, except consumer protection, and let the competition have at it. See if deregulation of this business can produce the same effects of other deregulation in recent years.

Chairman ECKART. Like airlines?

Mr. HUNT. You got it. The piddling in the pond has created a lot of problems for the health business and the public. ERISA, COBRA, Medicare Secondary is a killer, mandated benefits, IRS eliminated tax deductions, and unfair discrimination to the self employed.

Let us make a list of those Americans who have access to health care now. Employees of big companies, Government and municipal employees, welfare, Medicare eligibles, Indians, Veterans. I may have missed some. Of course, the healthy and the wealthy can still buy it.

It is hard to find someone to say that those people do not have a right to health care. But, it is also a crime that the rest of working America does not have that same right. The majority of costs to furnish the health benefit to the chosen people is being paid for by the ones who cannot have the insurance—small business and the self employed. Discrimination in America—this is wholesale discrimination.

Who is guilty of this crime? Elected representatives, special interest groups, insurance companies, health providers. It is time to

do the right thing. Enough is enough. Not the year 2000, as proposed. January 1, 1991—open access—open access to health care for all Americans.

We can waste money in space. We can help our enemies. We can bail out investment fraud. But, we refuse to take care of the people who pay the bills. So, we did not kill the golden goose. That would have been too merciful. We just let it die, at home, alone, and in pain. That is it.

[Mr. Hunt's statement may be found in the appendix.]

Chairman ECKART. Mr. Hunt, Samuel Clements told us many years ago, if you do the right thing, you will amaze your friends and astonish your enemies. Your admonition is well taken.

Mr. Gerry Rothlein.

TESTIMONY OF GERALD J. ROTHLEIN, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, CHILDREN'S MEDICAL CENTER

Mr. ROTHLEIN. Good morning. I would like to present some information regarding the Tulsa Health Option and also present the Tulsa Chamber of Commerce position on health care. I view myself as having some experience in this regard. One additional thing that I have been involved in that was not mentioned is the fact that I was one of the 15 members of the Oklahoma Health Care Delivery Council, and therefore, went through many of the same discussions as was related this morning by Dick Horkey. Dick and I have been involved at the chamber for about 12 years in trying to come up with some equitable solution to the health-care problems.

Oklahomans are certainly not alone as far as the type and variety of health-care concerns with which we must deal. Many of the problems which we face are the same as those faced by citizens in other States throughout the Nation.

Generally, these fall into two broad categories. How do we provide the broadest possible access to the best possible quality of health care. Two, how do we do so at the most affordable price? We have the same populations who are not receiving adequate health care as do other States, although as we have heard this morning, obviously, Oklahoma is quite high in comparison to other States. These are the employed uninsured and the indigent.

In addition, we have many citizens who believe that they have adequate health insurance coverage, but who are, in reality, either somewhat or substantially under insured. The fact that so many people have inadequate coverage means, by definition, that many of them are going to receive inadequate health care.

Also, the effect of placing virtually the entire cost of maintaining the health-care system on those individuals and businesses maintaining adequate health insurance coverage means that this latter group is, through a grossly disproportionate allocation of costs, subsidizing health care for all citizens.

The Tulsa Metropolitan Chamber of Commerce recognized this problem and attempted to address it in part through its administration of a grant from the Robert Wood Johnson Foundation. This grant allowed us to develop the Tulsa Health Option through the Tulsa Program for Affordable Health Care which significantly expanded the number of citizens in this community covered by health

insurance. Through this program and through other marketing approaches which we have helped develop and administer, we provide benefits to many individuals and at the same time, spread the cost over a broader base. We have also supported the enactment by the Oklahoma legislature of Ted Fisher's bill—Senate Bill 346. This legislation, as you heard this morning, creates a mechanism for providing health insurance to many more employed, uninsured Oklahomans and establishes incentives for their employers to participate.

The Tulsa Chamber has also considered what can be done for our indigent population. Existing funds are insufficient, and they are distributed inequitably throughout the State. Furthermore, the dollars are often not spent in the most productive ways. We believe that redirecting more existing funds into prenatal and perinatal care can greatly increase the benefits derived from available moneys. Also, we believe that it is worth investigating whether or not public moneys can be better spent through private insurance and health organizations. It may well be that significant efficiencies are attainable by reducing the cost of administering health-care funds with more money going directly into the providing of services. We are actively participating in the development of a pilot project with the Department of Human Services to evaluate these approaches.

But even if all Oklahomans and all Americans have adequate insurance coverage, we have not solved the health-care crisis. We must satisfy ourselves that intelligent decisions are made as to what type of services can and should be provided in the best interest of both individual patients and the population as a whole. We believe that managed health care can make a difference in this area.

We have seen the beginnings of progress as health maintenance organizations have begun to play a larger role in the marketplace in Oklahoma. These organizations not only act to insure that health costs are paid for; they also attempt to curtail costs, without undermining the quality of care provided.

They continue an initiative begun by the medical community itself—technology assessment. Such technology includes medication, medical equipment, and medical and surgical procedures used in health care and the organization and support systems that provide such care. Technology assessment is a form of policy research. It examines both the short- and long-term consequences of the application of technology. These consequences include clinical, societal, economic, ethical, and legal issues. As a State and as a Nation, we must encourage this process. We must continually look at the effectiveness, safety, and cost of medical technology for each clinical application. While the medical community is to be applauded for its efforts in this area, those of us in business and Government and the population as a whole must realize that there should be something other than an academic approach to this process. We cannot reasonably expect a laboratory which has invested heavily in a machine, to reassess its use before it is fully paid for.

The issues relating to providing good quality and cost-effective health care in this country are complex. There are no simple answers. Certainly, Government has an important role to play; but

the medical community, the business community, and all other segments of our State and our Nation must participate in the process. We hope to continue to be a productive player.

I appreciate having the opportunity to appear before this panel, and in the question-and-answer period, we certainly can get into some of the specifics of the program.

[Mr. Rothlein's statement may be found in the appendix.]

Chairman ECKART. I would like to explore that at that time.

Mr. Ron King representing Blue Cross and Blue Shield of Oklahoma.

TESTIMONY OF RON KING, BLUE CROSS AND BLUE SHIELD OF OKLAHOMA

Mr. KING. Mr. Chairman, members of the subcommittee. I appreciate the opportunity of being included on this panel and having the opportunity to talk to you about small business health insurance.

Much of my presentation, I feel, has already been given this morning, but we do share this concern. Before we get into our ideas, I would like to present and believe it is important that we understand how we got to where we are today.

First, I would like to talk about affordability. Second, I will discuss how the small group health insurance market problem has evolved over time.

In addressing the larger issue of why many small employers find health insurance unaffordable, it is important to understand that there are many components of health-care cost increases. These include practice patterns of providers, consumer demand for health-care services, new technology, demographic changes, and costs associated with medical malpractice, to name just a few. Each of these components and more affect the cost of health care and the cost of health insurance.

Blue Cross and Blue Shield of Oklahoma has a history of accomplishments in helping to control cost. We have worked with subscriber groups and have signed agreements with providers resulting in special payment arrangements that limit our subscribers' liability and assure that we pay a reasonable amount for covered services. Our cost control efforts also include case management, managed care and utilization, and medical necessity review.

In addition to these overall cost problems, small employers face additional costs from State-mandated benefits and provider laws adding to the cost of their health-care benefits for their employees. Large employers, through ERISA, can avoid the cost of these mandates by self insuring. The small employers do not have this option because they cannot bear the risk of large claims.

Other factors include a smaller base of employees and premiums over which to spread risk and high turnover of small group policies, which leads to both higher claims cost and higher administrative cost.

We recognize that certain insurer practices have an effect on both the cost and availability of coverage for small employers. However, these practices have evolved over time, in response to the demands of the marketplace.

Initially, every Blue Cross and Blue Shield of Oklahoma applicant was accepted for coverage, regardless of health status or age. Then, competitors entered into the health insurance market using underwriting practices such as age rating, charging higher rates, or denying coverage to higher risk applicants and imposing preexisting health condition exclusions.

The insurers who screened their applicants and accepted only lower-risk people were able to offer more competitive prices. The insurers with more liberal enrollment practices lost their low-risk enrollees to this better-priced coverages. They were left with higher risk enrollees who had nowhere else to go.

This process is known in the industry as adverse selection and explains why few insurers can accept high-risk groups and stay competitive in price. These selection problems are particularly acute in the small group market. Small employers are extremely price sensitive and more willing than large employers to switch insurers to get a lower price.

I would like to discuss some of the ideas we have for change. Blue Cross and Blue Shield's agenda for change includes increasing insurance coverage of low- and moderate-income individuals and families by offering innovative programs; assuring the availability of private coverage to all small employers at a fair price; reviewing health-care provider payment arrangements to assure effective use of subscriber premiums; and promoting legislative reforms that encourage the purchase of insurance and improve national and State programs for low-income individuals.

Blue Cross and Blue Shield of Oklahoma has been an active participant on nearly every major task force or committee throughout the State that is researching this problem. In January of this year, Governor Bellmon joined us in introducing a new health insurance plan designed specifically for the working uninsured, with a price target of less than \$50 for individual coverage. This program is called Basic, a safety net plan, and it is available statewide to individuals and families who are self-employed, employed by small companies and part-time employees. It is an age-rated product, medically underwritten, and our rate for an individual age 35-39 is \$48 per month.

You have already heard that the Oklahoma legislature recently enacted legislation to establish special low-cost health insurance coverage for uninsured small employers, and we commend Senator Fisher for his efforts in that area.

We believe that the insurance industry must find a way to make private coverage available to all small employers at a fair price. However, not all insurers can bear the risk of accepting high-risk applicants, and some way of fairly distributing the cost of these high-risk enrollees must be found.

We believe these changes will help move the small group insurance market from one where competition is based on risk selection to one where competition is based on administrative efficiency, services, and ability to control costs.

The third part of our policy suggests that health-care provider payment arrangements be reviewed to assure effective use of subscriber premiums. This is an area in which Blue Cross and Blue Shield of Oklahoma has never been stronger. We have signed

agreements with providers resulting in statewide networks. These networks allow us to negotiate special payment arrangements for our subscribers. In return, we pay the providers directly for their services.

The final areas of change that we are supporting are legislative reforms. Number 1, amending ERISA to preempt State laws that require costly health benefits be included in all insurance products. Number 2, we also believe that the Federal tax code should be reviewed to create tax credits or subsidies for small businesses. Number 3, we believe self-employed individuals should be allowed to deduct 100 percent of their premiums. Number 4, we support changes to the Medicaid Program to expand eligibility to persons at or below the Federal poverty level. Number 5, we believe we should explore establishing a statewide high-risk pool for uninsurable individuals and require that self-funded companies share in the financing of risk pool losses.

In closing, the private and public sectors must work together to improve access to care for the uninsured. We will continue to pursue enhancing private sector coverage. This problem can be helped if we have governmental support to offer more affordable packages and tax incentives for certain employers to offer benefits. Together, we can affect the underlying problem of escalating health-care costs. Thank you.

[Mr. King's statement may be found in the appendix.]

Chairman ECKART. Thank you very much, Mr. King. Since you have the microphone, it may be easier just to kind of go back down the way we came. The advantage, Mr. Hunt, is that it keeps you squarely in the middle.

Mr. HUNT. Story of my life. I am always in the middle.

Chairman ECKART. What the great Texas agriculture commissioner once said about being in the middle of the road. It is where the yellow stripes are. You only find dead armadillos in the middle of the road. So, you might want to keep that in mind.

Mr. King, what was your reaction to the testimony of the National Association of Insurance Commissioners, particularly as it reflects on rates and terminations?

Mr. KING. As a national policy, we have been working with the NAIC on their program, and much of their program has been as a result of working with our committee out of Washington, DC, and Chicago. We, in most part, support most of the NAIC recommendations. We believe in a matter of fairness in that whatever is imposed be imposed across all carriers. With that, we would support the NAIC document.

Chairman ECKART. Mrs. Frame saw a huge increase in her premium rate. She had been a member of yours for 30 years. What contributed to her rates going up? Maybe not hers in particular, but the phenomena that struck small businesses like her.

Mr. KING. There are several factors that we use in establishing a rate base. In Mrs. Frame's case, she is in what we call a pool group where we pool all employers with employees between the size of 10-49. We do not rate individual groups within that pool, that is a total pool rate. There are any number of factors that we have seen. As I mentioned, the technologies that we have seen coming into play. New diseases, such as AIDS, has an important part of that—

the rising prices that we see with physicians and the hospitals, utilization, in general, has taken a dramatic increase that we have seen throughout all of our groups. So, there are any number of factors that would pertain to that price increase.

Chairman ECKART. When you say utilization, do you mean just generally across the group that she would be a part of? Do you watch utilization, is that directly related to perhaps the aging of that group?

Mr. KING. Aging is very much a part of that. But, once again, keep in mind, it is the utilization of that pool.

Chairman ECKART. The pool; I understand that. Would Basic be a good deal for someone like Mrs. Frame? Would your Basic be a good deal for her?

Mr. KING. That is a decision that each individual will have to make. When we set up the program, we went throughout the State and conducted interviews and had some focus sessions with different employers. However, Senator Fisher hit on a point this morning that, unfortunately, a lot of people want something for nothing. The program we recognize is admittedly not a comprehensive program. It is not for everyone. It is something that is available. It is a low-price product that does provide protection for basically hospital-type services and some physician services and other limited benefits.

Chairman ECKART. How will you react to Oregon-type suggestions of actually establishing priorities of what you pay—ultimately rationing of certain kinds of services or even procedures that will be declared by fiat of law to be nonreimbursable—exotic transplants. Near me, there is a hospital in Pittsburgh that you have probably followed in the newspapers. It is doing some remarkable things. They just did a transplant that involved the entire small intestine. It holds out the only hope for that person, but the cost there is phenomenal. Let me hear a philosophical, I suppose, reaction to that being on the horizon.

Mr. KING. The Oregon program is something, of course, everyone is watching. It is something that the rational—rationing health care is something that, of course, we are not in favor of. We do recognize that it is a very price-sensitive market. There are certain instances that the large claims that we are seeing are becoming much more prevalent as technologies advance, the procedures advance. That does nothing but drive costs up. We believe that we will have to come to a point. Unless the appetite that we see with the public changes, there will have to be a point. There are going to have to be some choices made.

Chairman ECKART. One of the first witnesses on the first panel said that employees of small businesses are, in fact, not sicker than employees of large businesses. In fact, the quote continues, the HMO provider found that it had a lower per capita cost for the small business enrollees than for its traditional large business enrollees. Does your testimony suggest the opposite? That employees of small businesses do have different experiential rates of utilization?

Mr. KING. I really have no information distinguishing between what we call small business, which was 2-9 size groups. I do know that our average rate increase in 1989 for that category was 16 per-

cent, which was very similar to what we implemented with the other size groups in our company.

Chairman ECKART. Brett, do you keep those statistics—utilization by categories?

Mr. DICKEY. No.

Chairman ECKART. You do not. Mr. King, thank you very much for being with us.

Mr. Rothlein, first, a word of congratulations. I think the Tulsa Chamber is not alone out there, but there is not a very large group of you who I think are struggling to come to grips with this problem. I think at least one of the things this gentleman wants to do is to—whichever way we step off—acknowledge that you can craft some peculiar solutions that may, in fact, be helpful to the national debate. I guess it is a little bit like what I am fond of telling my folks when I am home. You might not want Washington to do it for you, but you do not want Washington to do it to you. I am very much impressed with what you have tried to do.

Let me ask you about your proposal. How do you market it? How do folks find out? Do people come scrambling to you because they have just got canceled? Do you aggressively seek employers? Is it a tool which you use to bring folks into the chamber? Talk to me about how you use this device and how people come to you.

Mr. ROTHLEIN. Yes; it is a combination of all of those, but let me go back to the initial phase of the program with the combination of the Tulsa Business Health Group, which is made up of large employers who felt very seriously—very strongly—that they were being discriminated against, and everyone here, I guess, feels discriminated against in terms of the cost shifting. Where hospitals and physicians, et cetera, had only a few people to charge, and so large businesses were the most viable, and yes, they could provide insurance for their employees. But, as it became larger than their pension costs and other costs and became the number one cost on the income and expense statement, people in Tulsa and the large businesses began to be greatly concerned about it.

So, with the help of the Robert Johnson Foundation and a \$1.5 million grant over 4 years, what we were able to do is bring together forces at the chamber and also within the medical community and also large businesses, et cetera, to really try to create our own risk pool. Everybody understands the concept of a risk pool, and large businesses were willing to take some hit to it because they were already paying most of it. The combination of the Robert Wood Johnson Foundation grant, which gave us credibility—the fact that they selected us as one of nine programs around the country to receive the CPAHC grant, Community Programs for Affordable Health Care, and then the unprecedented step by the Chamber of Commerce to endorse providers as being cost effective and also creating affordable plans—we were able to market the program extensively. We used a lot of the grant money to market the program. Really, we did not make any decisions in terms of coverage or anything like that, but we did select providers that could be part of the Tulsa Health Option. The significant occurrence was that the large businesses were getting approximately the same rights as the small businesses as they were being introduced into the plan.

Today, we have approximately 34,000 lives covered under the Tulsa Health Option. The grant ceased in March, and we returned some of the money. We did not spend all of the money that we had from the Robert Wood Johnson Foundation. It is currently under the auspices of PacifiCare, who designed a program specifically for the chamber, and as an HMO, we felt very comfortable with them managing the care because that is also a concept that we have, that managing care is also a very important part of holding the costs to a level that is reasonable and trying to control the premiums.

I might, for your purposes, compare the Cleveland premiums to the Tulsa Health Option premiums as they were this last quarter or close to this quarter. The Tulsa Health Option has on average a single premium of \$89, compared to \$97 for the Cleveland Program. The individual—that is the individual coverage. The group coverage was—I believe I have got this mixed up—oh, here it is—the family coverage under the Cleveland Program averaged \$261 per month compared with \$253 under the Tulsa Health Option.

Chairman ECKART. May I have those two documents to put in the record?

Mr. ROTHLEIN. Certainly; I have some information that I will turn in.

[The material referred to may be found in the appendix.]

Chairman ECKART. Thank you.

Mr. ROTHLEIN. Then, we also compared the large business firms belonging to the Tulsa Business Health Group. Then, part of the Tulsa Health Option to the Cleveland large businesses where they have also gone out individually. The Cleveland plan averaged \$187 per month for single coverage, compared with \$101 a month for the Tulsa Business Health Group is very favorable. Family coverage on an average, \$435 under the Cleveland plan, compared with \$279 for the Tulsa plan. So actually, the whole combination of rates here in Tulsa, despite the fact that we are overbedded and all sorts of things like that, I think compares quite favorably.

Chairman ECKART. We see some of the consequences in those numbers in Cleveland where health-care costs are better than twice the national average. We sustain a number of major teaching hospitals and the like, and you have—it does calculate into it.

Let me ask Mr. King, Mr. Rothlein, and I am reminded that we must surrender this room as close to noon as we can, so Mr. King, maybe because you can help, you mentioned that we do not have enough funds to deal with the poor. May I ask what the Tulsa experience is, or perhaps you can reflect that more statewide, Ron. We have an experience in the Cleveland area where just a handful of hospitals are doing all the indigent care, for which they do not get reimbursement. What is that nonreimbursed percentage of area hospitals, and to what extent is it crimping their ability to contract with other health-care providers?

Mr. KING. I will answer that. First, there are several elements of that. When you talk about uncompensated care, you can really look at several different facets. I mean, Medicare is uncompensated care when it averages 68 cents on the dollar. The true indigent population—we are the largest city in the United States without an indigent hospital—without any particular—

Chairman ECKART. You do not have one?

Mr. KING. There is no public hospital here in Tulsa, which is a significant problem for the city of Tulsa and the surrounding regions, although it really is a problem, I guess, to 75 of the 77 counties in Oklahoma. I believe Cleveland County and Oklahoma County are the only two that receive the benefits of the Oklahoma teaching hospitals in Oklahoma City. So, we have had a significant amount of uncompensated care in this community. Medicaid does not pay for a whole lot of things. Therefore, it is a large bill that gets tacked on. That is why the large businesses got into a position where they said, we are no longer willing to take it and we need to come up with a solution. That is really the advent of the Tulsa Health Option.

Chairman ECKART. I am reminded of statistics we received this morning that the Oklahoma rate is 7.36, which was sixth highest in the country, compared to the national rate of 4.7. I think that does portend well for you, but in Ohio, we have other compensating matters to deal with it.

Mr. Hunt, if we could slide the microphone down. I do not want to start a war here, Mr. Hunt, but give me your assessment of the Blue Cross Basic product and how it fits into the scheme of what you try to advise folks who come to you.

Mr. HUNT. I have not actually seen the actual statistics of Blue Cross—the rates on there. All I have is hearsay. So, the hearsay I have that the premium is not low enough compared to their Health Check Plan to warrant the difference in loss of benefits. Now, that is just hearsay. I have not seen—

Chairman ECKART. This is what folks have told you?

Mr. HUNT. Yes; people who have called me. I get lots of calls. I get lots of referrals because a lot of agents are completely pulling out of the health insurance business because it is too much of an ordeal, so they shift the things over to me. I cannot help a lot of the people. But, this is the story they are telling me. They say, I got the rates from the Health Check. Then, I got rates on that basic plan. It looks to me like the benefits drop is much greater than the premium benefits. Now, I would say it is hearsay. I have not been exposed to that.

Chairman ECKART. Mr. Hunt, you used a word that I made a note of, medical meltdown.

Mr. HUNT. Yes.

Chairman ECKART. How much worse can it get? This is the fifth of these hearings that we have gone out and tried to do, over this past year, to getting real testimony from real people. Now, tell me where you think it is all headed.

Mr. HUNT. I believe it is imminent—that it is coming and it is coming fast. I have some literature that is furnished by the National Underwriter. It says in 1988, Prudential lost \$93 million; Metropolitan lost—no; Metropolitan made \$51 million; Mutual of Omaha lost \$104 million; Aetna lost \$53 million and is no longer writing individual health insurance with a bunch of others; Connecticut General lost \$7.7 million; Travelers lost \$27 million; Principle lost \$98 million; Continental Insurance made \$6 million; Allstate lost \$148 million and pulled out of the market; ProvidentLife and Accident lost \$153 million and I do not know what their status is;

Guardian Life lost \$109 million and I do not know their status; Lincoln National lost \$93 million and that was in 1988, which shows a good sign because the overall market lost \$198 million in 1987. Now last year, they only lost 830 of the 12 biggest providers.

Chairman ECKART. May we have that for the record.

Mr. HUNT. Yes; I have got one.

[The material referred to may be found in the appendix.]

Chairman ECKART. Thank you very much.

Mr. HUNT. That is just one fact. I think it is imminent and we are holding on by the skin of our teeth. As I say, I do not need any more business. I am busy trying to just keep my obligations and clients I have got. I get captive agents sending me business. I get P&C guys. I got a guy—you know—it is just from everywhere. I am in the phone book—a little bitty place in the phone book. It is very, very frustrating to the people when you have to tell them things they do not want to hear. In ancient times they always killed the messenger. I am pretty close to that right now.

Chairman ECKART. To kill or be killed?

Mr. HUNT. Both; I cannot understand why anybody would have a phone that they take with them. It does not make sense to me.

Chairman ECKART. It is like beepers, Mr. Hunt. They were a terrible invention.

Mr. HUNT. Who would want them? I completely have to get from it—just walk away from it—do not take the phone calls and do other, I always have to take the clients I got now, but I do not always return some of the calls—the calls I get other places.

Chairman ECKART. Mr. Hunt, my last question was to be directed toward you. Your message is as strong as any we have heard at any of the four other hearings. Do you think your viewpoint, as clearly articulated here, is represented in the council here in Oklahoma, in the chamber's considerations, the Oklahoma State House? I mean, one of the points you made regarded responsibility. It started with us. You talked about the balance of Government. You talked about the lobbyists, organizations, institutions—very focused comment. I appreciate it. Do you feel that the institutions trying to respond to this question—

Mr. HUNT. I do not think they can do it. I think we are on a run-away train and the engineer is dead and we do not have a fireman. I think it is really that bad. They cannot do anything. They are locked into their corporate systems. They are locked into their structures. No one has got control. We have got to have someone to bring the things together.

I am not saying that we have to throw out everything; but we have got to have a logical, nonpartisan position which is going to protect the public. If we do not protect the public, we are all going to be out of business anyway. So, we cannot continue not to have some kind of a national focal direction. If we can utilize the administrations, the knowledge, and the things of the people we have already got in all these deals—they are struggling, too. They have got their bills and stuff to pay. They have got the thing to do it. They have got to show a profit. They have got board of directors.

We have got to have profit; we cannot stay in business. We cannot continue to have profit as long as we are continually knocking each other around and putting the blame on somebody over

here. They are putting it on someone—there is a lot of money flowing. Somebody has got to be making some money somewhere. Somebody has got to be getting some money out of this. Now, everybody says they are not making money. Now, somebody is making it. It is not the agents, not on group insurance, anyway.

Now, a lot individual salesmen are making some good bucks because they make 40-60 percent commission. When they write one up front, they do not care if it is here next year or not. Mine, they got to stay. If they do not stay, I am out. Plus, I have to live with these people. They have my phone number and I have an office at the house. They know where to find me. So, a lot of these guys on the street now selling insurance—they have the shoes; they do not have no soul. So, there is a lot of scams. They call you up. They represent themselves as the Small Business Association, and they are not the Small Business Association. I wrote them. Those guys did not answer me back. Not the Small Business Association.

We have got a bad situation, and it is going to blow. It is going to blow pretty fast. If you look at the rates coming out on the small groups, it has already blown. You got a man, he makes \$500 a week. That is fair money in Oklahoma now. If he is 50 years old, he is paying \$500 a month. He cannot pay 25 percent of his income. He has got to put food on the table now, or the possibility of stiffing some hospital—if they will even let him in. We had two hospitals close their emergency rooms here.

It is bad. It is coming. It is coming fast. Nobody is doing nothing. That is what has been making me mad for the last 2 years. I get all this stuff coming in. I write letters. Nobody writes me back, or they send me a dumb answer that they picked up maybe out of the waste basket and said, hey, send this to this guy. It is very frustrating, but nobody will take charge. No one. I am not a public person, so what am I going to do?

Chairman ECKART. I think you took a nice step today, and I am grateful that you came.

Ms. Frame, very quickly, was there any reason for an increase in your premiums? I mean, did you have high risk employees? Did you have a lot of folks getting old?

Ms. FRAME. No; this is what is so frustrating, like with the Blue Cross, being with them for 30 years and we had no big, big health problems in that time, just babies and small little operations and things. Then, for a small business that takes everyone in the business working every day just to try to make a profit, to try to put a lot of time to find an insurance company that you feel is competent and reputable and checking with the insurance commission and all this, and all these people like he is talking about that call you with all these great deals. Then, you have got these employees that have been with you for 19 and 20 years, and you say, hey, if I switch, what might happen to them? They might not have any health care.

At \$500 a week, they do not pay that in Checotah. There is no one hardly that makes that kind of money. This is just an extreme problem. It was just a heart-rendering situation. It took so much time to try to change—to make that decision to change and affect all these loyal customers—loyal employees.

Chairman ECKART. Blue Cross Basic did not do it for you?

Ms. FRAME. Who?

Chairman ECKART. Blue Cross Basic does not do it for you?

Ms. FRAME. No; their deal at the time was that they had lost money for 2 years—and I understand that and I understood all the high costs in health. Like he said—he just kind of puts it all on the—just kind of nails it all down—the public is so frustrated because we are finding no answers and we are getting all these pitches and all these words, but we are just not getting any workable solutions for the little man out there that when he gets his paycheck, a certain amount is taken out by the Government and by this and that. But yet, he seems like he is not getting any protection or any real help that he can understand and feel like, hey, they really recognize John Doe down here. In January of this year, my husband had a heart attack and four-bypass surgery. OK, we are in this new program now. We had 10. You had to have 10 to get on it. OK, now how are we going to switch? Who is going to want him? I mean, he is healthy now, but he is still a very high risk. So, I mean, are we locked in with a company that can increase their rates at their whim like someone said here, is there no degree of rate increase anywhere? Can everyone just do that whenever they want to?

Mr. HUNT. Let me say one thing. If you have been with Blue Cross and Blue Shield and you drop below 10, they would let you move down to the 2-9 bracket and they would change your benefit, change your rate, and they would also give you dental, but you would not be out in the street. In most of the 10-plus companies, if you go below 10, they cancel you. You have 90 days, 60 days to bring your group up. If you do not, you are out. In Oklahoma, we are going down, so we have a lot of dumping. So, if you had stayed with the Blue Cross, even though they went up—and I am not taking up for anybody—I am just saying if you stayed with them, you would not be in the situation you are in now because of that.

But, salesmen come and they tell you all these wonderful things. I do not see how anybody buys insurance from a company salesman—a guy who works for the company does not work for them because like I say, he does not care. He has a quota. He has to make it. He has to move here. They have all these meetings and all those awards they give them. If you do not buy it—if you do not buy it from your own agent, you are hurting yourself now. I am not speaking—I do not belong to an independent agent organization. I do not belong to nothing. I am not a joiner. I am just saying that is the way it is.

Chairman ECKART. You belong to this panel.

Mrs. Greer—and your remarks, by the way, belong to the record now. Frankly, I would not be the least bit surprised if you see me quoting you from time to time.

Mr. HUNT. That is OK. Just do not mention my name.

Chairman ECKART. Mrs. Greer, how did you figure out how to do all that you did?

Ms. GREER. I contacted my agent, Mr. Ellis, and I also—we work in insurance claims, so I know a little bit about the legal.

Chairman ECKART. Then, you are exceptional. Most folks would have just been rolled over by what happened. I do not mean this to be gratuitous to you, but a lot of folks probably would have given up.

Ms. GREER. A lot did.

Chairman ECKART. As you worked your way from one company to another to another, were you satisfied at all with the system, was trying to help you, or were you just kind of like getting doors slammed in your face as you turned?

Ms. GREER. The only one that ever tried to help was the Oklahoma Insurance Planning Commission and Mr. Ellis. Health Accord did not even return my phone calls after awhile.

Chairman ECKART. Is there no statewide toll-free number to call in terms of seeking assistance in these kinds of matters or a State agency for you to refer to?

Ms. GREER. Not that I know of.

Mr. HUNT. The Insurance Commissioner has an 800 number and the Health Planning Commission has now been moved over to the Insurance Commissioner's responsibility. But, he was not at the time. They were two separate people.

Chairman ECKART. For not ever having done this before, Mrs. Frame, Mrs. Greer, Mr. Hunt, you sound like you have done this before. If you have not, boy, you are candidates for rookie of the year. You have done very well.

To the chamber, Blue Cross and Blue Shield, your related companies in other States appeared before me before and I understand that sometimes, you walk around feeling like a big old bull's eye has been painted on your back. But, I do want to say that one of the reasons we do this is to hear from real people.

Before I adjourn, let me ask my colleague if he has a question or two.

Mr. SYNAR. Yes; thank you, Dennis. Just a couple of things.

Joan, in your testimony, you said, we need to step in with a working plan. The previous panel kind of testified to the fact they think we ought to try to go the voluntary route. Do tax incentives first. But barring that, they would not be adverse to a mandatory type of plan in order to try to get the protection and not put anyone at a competitive disadvantage who would be responsible and do health. Do you disagree with that?

Ms. FRAME. I think the Government is going to have to step in with some kind of plan. The tax credits and all these things—those are incentives and you get stuff like this all the time. But, this means more paperwork for the little business owner that does not have a lot of time in the office to keep up with all these little different Government regulations.

I was wondering—like years ago, when the State Insurance Fund was created for people that could not get workman's compensation. I do not know what the guidelines for all that purpose was, but it helped people that could not get insurance somewhere else. It offered a plan for businesses that could not offer it or people that could not—the Government came in and offered something else.

Mr. SYNAR. Juli, let me ask you. You said that your present insurance bill is about \$300 per month. Is that for your husband, yourself, and your children?

Ms. GREER. That is for—I had to go into family. There was only two—I would like it when we get all under one as family, but we had to break out. My husband took single, and then I had to take the children and myself.

Mr. SYNAR. What is the total bill for your family combined per month?

Ms. GREER. Gordon and I and the kids?

Mr. SYNAR. yes.

Ms. GREER. \$279.45.

Mr. SYNAR. So, we are looking at somewhere in the neighborhood of \$3,200 a year just in basic health insurance for you and your family, correct?

Ms. GREER. Yes.

Mr. SYNAR. You are a small businessman—it is just you and Gordon in that small business, correct?

Ms. GREER. No; it is owned by his father.

Mr. SYNAR. OK. So, how many employees are there?

Ms. GREER. Besides Gordon and myself, there is one other.

Mr. SYNAR. I do not know what your profit picture is or whether you have good years or bad years, but \$3,200 a year is a pretty healthy bite out of that, is not it?

Ms. GREER. Yes.

Mr. SYNAR. It puts you, in some ways—you have to tack that onto your cost, do not you?

Ms. GREER. Yes.

Mr. SYNAR. That is then passed on to what customers you do have, correct?

Ms. GREER. Not really.

Mr. SYNAR. Does it put you in a noncompetitive position, do you think, with other people who may be in the same business that you are that may not have health insurance?

Ms. GREER. Well—

Mr. SYNAR. Let me ask you this. Is this part of your family budget? Do you put it in your family budget?

Ms. GREER. No; my father-in-law pays for it out of the business. We do not pay anything.

Mr. SYNAR. That is very interesting. I want to commend you because I think, like Dennis said, your story is one of tenaciousness and determination that, too often, we do not find in this game of trying to find the best deal and best plan for health.

Let me conclude, if I could, Mr. Chairman, by first thanking you and the staff for being here. I think this has been an excellent presentation on the serious problem that we face as Oklahomans, as small business people, as a Nation, in trying to deal with this issue. Jerry, in your testimony, you said something which I think maybe—you applied it to an individual, but it may be, in many ways, a statement about the problem that we are facing with all health care. You said that the lady—maybe a Nation was afraid to go find the truth. The truth is that we have a serious problem in this Nation. In the State of Oklahoma, I think it clearly has been identified today as something we need to address.

I hope that this hearing and the input that we have received today leads us down the path to coming up with some solutions because as you concluded Jerry, and I want to quote you, if we do not solve this problem, if we do not come to grips with it with whatever solution it is, we are all destined to do, as you said, die at home, alone, and in pain. I think as a society, we deserve a lot better. Thank you all for being here today.

Chairman ECKART. The next step, of course, is the panel will conclude a report to the Congress. The Congress tends to look only at the big picture. Within that large pictureframe, as we have discovered by going into communities as we have, there are lots of little faces. Faces that every day deal with these questions from a very particular dimension. That is the purpose, to visit with real people and to hear real stories—some difficult and some successful. Mr. Hunt.

Mr. HUNT. One more observation that I need to mention while I am thinking about it is that there is a lot of flaws in a lot of policies and you do not know about it until it is too late. For example, most group policies do not cover injuries on the job. You have to have workman's compensation for that. In the State of Oklahoma, workman's compensation is voluntary for the owners of the business, the officers, and those kind. It is voluntary for them to do that. So, many of them elect not to do it because of the cost factor. So, if they get hurt on the job, they have a bill to take home they did not know about.

There are other policies out there that have flaws in them that it is only for employed people. A guy gets disabled and he is off 3 months not working on the job. If it is a small business, that guy is thrown on the street with no insurance. There is flaws in those policies. There is a bunch of flaws in those policies, and everybody sells them, but nobody is reading them.

Chairman ECKART. Mr. Hunt, I think on that note, we will give you the last word. This hearing stands adjourned.

[Whereupon, at 12:11 p.m., the subcommittee was adjourned subject to the call of the Chair.]

APPENDIX

MIKE SYNAR
28 DISTRICT, OKLAHOMA

COMMITTEES
ENERGY AND COMMERCE
JUDICIARY

GOVERNMENT OPERATIONS

SELECT COMMITTEE
ON AGING

Congress of the United States
House of Representatives
Washington, DC 20515

WASHINGTON OFFICE
2441 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-2701

DISTRICT OFFICE
2822 FEDERAL BUILDING
125 SOUTH MAIN STREET
MUSKOGEE, OK 74401
(918) 687-2533

Statement of Congressman Mike Synar
August 10, 1990

Here in Oklahoma we have one of the nation's highest rates of working people who have no health insurance. Business people have responded to this crisis by developing some creative solutions, ~~which are not~~. The problems we face in Oklahoma can be seen as a microcosm of the problems people face across the nation. The solutions developed here should be kept in mind as we as a nation begin to formulate national solutions to this problem.

There is some anxiety in the small business community over the possibility of government mandating health benefits. But I'm not certain that is the right approach to solving the problem of the vast number of uninsured workers in this country because currently, the cost of such insurance is too high. The solution must be found through the cooperative efforts of the insurance industry, businesses, the medical community and the government.

The problem of access to health care and insurance is multifaceted. Businesses are trying to do the best they can, but for many the cost of providing health insurance to employees is prohibitive.

For example, one constituent of mine contacted my office about the problems he has. He feels health insurance is important, but it takes 20% of his payroll to provide health insurance to his employees. ~~It~~ It is difficult for him to remain competitive with the business down the street that pays its employees 25 cents more per hour but provides no health insurance. He has lost employees who found the slightly higher pay more valuable than health insurance.

Americans don't appreciate the value of health insurance. Many people would prefer those extra few cents an hour over a good health insurance policy. Regretfully, too many people don't see any reason to have health insurance until they need it. By then, they are usually unable to get health insurance because they have a preexisting illness.

People should look at health insurance the same way we do car insurance. In Oklahoma, car owners are required to have car insurance. When you buy a car, you figure the price of insurance into the cost of the car. We should approach health insurance in the same way by planning it into the family budget as a normal cost of living. Getting every person in this country insured and keeping them insured would benefit all of us.

We also need to change the attitude toward health care so that the focus is on preventative health care. Too often people seek medical care only when they have a problem. Everyone should go in for regular care instead of waiting until a serious problem exists. This basic step would reduce the cost of health care and insurance for all of us.

I don't have the answers. I want input so that we can work together to find solutions. That is why I'm here. I want to be able to return to Washington with more ideas and suggestions from people who have faced these problems. Business, the insurance industry, consumers, the medical community and government must all work together on this to find a solution.

STATEMENT OF TED V. FISHER
OKLAHOMA STATE SENATOR
DISTRICT 12

TULSA, OKLAHOMA
AUGUST 10, 1990

SUMMARY

In 1988 the Oklahoma Medical Research Foundation published a report which estimated that 636,000 Oklahomans were medically uninsured. The medically uninsured represent 22.8% of Oklahoma's non-elderly, civilian population. As a result, Oklahoma has the sixth highest rate nationally of unsponsored health care. The report found that the lack of adequate and affordable health insurance in the workplace was a major contributor to uncompensated health care.

In response to the findings of this report, the Oklahoma Legislature enacted SB 346, the "Health Insurance Opportunities for Employed Uninsured Oklahomans Act". Under the act, a public board is appointed to design a group basic health benefits plan. The board will certify private insurers who will offer the plan to employees and their dependents through their employer. Participation in the plan by employers is elective, not mandatory. Eligibility for participation in the plan is not limited to small businesses.

Employers are required to pay one-half of the premium attributable to the employee. To offset the initial cost of providing coverage, the employer will receive a tax credit of \$15.00 a month for a two-year period for each employee covered under the plan.

Mr. Chairman, members of the committee:

My name is Ted Fisher. I am a resident of Sapulpa, Oklahoma, and a member of the Oklahoma State Senate, representing District 12, which borders the Tulsa area. I have served in the Senate for the last four years and have served as Chairman of the Senate Economic Development Committee for the last two years.

My interest in Oklahoma's business development, my familiarity with the insurance industry, and my deep concern about the growing cost of uncompensated health care prompted my introduction in 1989 of a bill to make insurance more accessible to Oklahomans, SB 346. My purpose today is to explain the provisions of SB 346 and to provide insight into issues considered and decisions made as the bill developed.

In October of 1988, the Oklahoma Medical Research Foundation, Center for Health Policy Research, published a report entitled "Medical Security in Oklahoma". The report found that Oklahoma had one of the highest rates of uninsured citizens in the nation and placed the blame on two factors:

1. current standards prevented a large number of impoverished Oklahomans from qualifying for Medicaid; and
2. adequate and affordable health insurance was not available in the workplace.

The report estimated that 636,000 persons in Oklahoma were medically uninsured. Of that number, an estimated 536,000 were the working uninsured and their dependents (estimated at 400,000 by other sources) and 100,000 were the unemployed and their dependents. Overlapping this population were the uninsured poor estimated at 245,000 persons. Included in the medically uninsured population are 30,000 persons which the report categorizes as uninsurable. (I have heard figures as high as 40,000 to 50,000 for this population.) The medically uninsured represent 22.8% of Oklahoma's non-elderly, civilian population (figures were based on 1986 data), a figure which was considerably higher than the median rate of 16.9% for all states and the District of Columbia.

We all know that free health care does not exist. Someone else pays the bill for the medically uninsured, whether it be through higher insurance costs for those who purchase insurance, higher medical charges to those who can pay, higher taxes to pay for social services, or unprovided medical services. The report assessed the impact of this health care cost shifting by using the "unsponsored care ratio", a measure which calculates the percent of hospital expenses which are shifted to private payors or absorbed by the hospital. For Oklahoma the rate was 7.36% which was the sixth highest ratio in the nation. The national rate was 4.79%.

The health care system is dependent on the ability of patients to pay for services. Few, if any, citizens can pay for extensive health care services unless they are covered by health insurance. As the

uninsured population increases, the viability of the health care system is threatened. The high percentage of uninsured and the comparatively high rate of cost shifting in Oklahoma is, indeed, cause for alarm.

It would be wonderful if we could ensure the availability of insurance for all persons, whether they were employed or unemployed, healthy or disabled, young or old. Some states have chosen to create state-backed, high risk pools for the uninsurable. Others have chosen to mandate that employers provide insurance for their employees. Oklahoma has not taken either of these approaches.

As a rule, Oklahomans are very skeptical of the government's ability to succeed where private industry has been less than successful. Passage of legislation which created a state-run program to provide insurance for the 636,000 medically uninsured or mandated that employers provide insurance was not a viable option in my opinion.

Estimates placed the cost of providing health care for the uninsurable population (30,000 to 50,000 persons) at close to one billion dollars. With a state budget of \$3.24 billion, the price tag for solving this portion of the problem was beyond our means at this time. Therefore, rather than tackle the entire problem, I chose to address the portion that I thought had the greatest opportunity for resolution, the working uninsured. We had two options: mandate insurance or provide incentives to encourage its purchase. I opted to

address the problem by providing the right* product for the right price and incentives to purchase the product.

SB 346 was not the result of my efforts alone. Other legislators, particularly Senator Howard Hendrick and Representatives Steve Lewis and Cal Hobson, were actively involved in the bill's development. Additionally, in 1989 Governor Bellmon formed a task force of concerned business leaders, community leaders and insurance industry representatives, under the direction of Richard J. Gilbertson of the Oklahoma Employment Security Commission, to recommend a plan for making low-cost insurance available to the working uninsured.

During the interim between the 1989 and 1990 sessions, under the leadership of Robert Fulton, Secretary of Social Services for Oklahoma, the Governor's task force and the legislators and consultants involved with SB 346 met to hammer out differences and to develop a basic health benefits plan and method for offering that plan to working Oklahomans. The work of this consortium of interested parties produced the final version of SB 346, the "Health Insurance Opportunities for Employed Uninsured Oklahomans Act", which became law in May of this year.

SB 346 represents a partnership between government and the insurance industry. Under the act, a public board is appointed to design a basic health benefits plan. The plan is offered to employers by private insurers who are certified by the board to offer the plan.

A refundable tax credit is used as inducement to employers to purchase the plan. The act does not create a public insurance company. The act does not make insurance coverage mandatory.

Several basic issues were addressed and resolved before the design of the act was finalized. Some of these issues were: who should be eligible for the plan; to what degree should government be involved in designing, marketing and reserving the plan; which benefits should be included, excluded or limited; and what cost should government bear.

Let me address eligibility first. The parties involved in the legislation's design intended that health insurance be made available to employers who had previously been unable to provide insurance for their employees. The insurance plan offered under this act would not be a deluxe model. It would be a plan that would offer basic health benefits at a minimum price. Keeping the price affordable would be a high priority. Therefore, we did not want to create a situation in which employers, who were able to afford better coverage for their employees and, in fact, had provided that coverage, would drop their current policy to purchase the state-certified plan. We wanted to target a market that the insurance industry had largely ignored, not cut inroads into a market already served by the industry.

The legislation was drafted with language to accomplish this intent. An eligible employer was defined as one who had done business in

the state for a year or more and was not providing health insurance for at least 75% of its employees. To discourage employers from dropping coverage to become eligible, language was added which excluded employers from eligibility for a fifteen-month period prior to the offer to purchase the state-certified plan.

We debated whether to limit eligibility to small businesses as other states, such as Oregon, have done. On one hand, we felt the primary target for a low-cost, basic health benefits plan should be small businesses who are least able to afford health insurance for their employees. However, our other concern was making insurance available to employees and their dependents who currently did not have access to coverage. Limiting eligibility to small businesses was contrary to our objective of providing accessibility to as many uninsured as possible. In addition, enlarging the pool of eligibles allowed a greater spreading of risk and decreased the possibility of adverse selection.

The legislation requires that the state-certified plan be offered through employers to their employees and dependents. The plan is designed as group coverage, and minimum participation requirements, based on the number of workers employed, are included in the legislation. Employees qualify for coverage if they are state residents, work a minimum of 24 hours a week, and are not covered by a group health insurance plan offered by their employer.

Our next major hurdle was determining the extent to which government should be involved in the administration and delivery of the plan. Our debate ranged from creating a state agency which would operate like an insurer similar to our State Insurance Fund which provides workers' compensation insurance, to creating a Board, similar to our State and Education Employees Group Insurance Board, which would contract with a third party administrator to perform insurance functions and would manage reserve funds for the plan, to creating a Board which would design the benefits plan but would contract with either a single or unlimited number of insurers to offer the plan and assume responsibility for adequately reserving the plan. In fact each of these concepts appear in the various versions of the bill.

The final version of SB 346, as enacted into law, creates an eleven-member Oklahoma Basic Health Benefits Board. The Board will design the plan which will involve determining minimum benefits, scope of coverage, maximum premium amounts and other provisions such as coinsurance, deductibles, payment schedules and lifetime benefits.

Although the bill leaves the overall responsibility of designing the plan to the Board, it does specify certain benefits that must be included as well as certain limitations and exclusions. As an example, coverage for cosmetic surgery, chronic fatigue treatment, and obesity remediation is excluded. Transplant coverage is limited to certain procedures. Payment limitations for preexisting

conditions are specified. Prenatal care is specifically included and not subject to any deductible, copayment or preexisting condition exclusion. With the exception of businesses comprised of two or less persons, the plan is prohibited from requiring evidence of insurability. The plan may not vary premiums or benefits by age.

The inclusion and exclusion of these benefits were based on actuarial studies conducted to determine the feasibility of a low-cost, basic health benefits plan. These studies support the belief that a plan can be designed which offers basic health care coverage for a cost of approximately \$60.00 a month for each adult participant.

The Board will certify insurers to offer the plan who then will market the plan to employers under their policy. The policy must include the minimum benefits approved by the Board and will not be required to include any other state mandated benefits. Benefits cannot be reduced and premiums cannot be increased unless the insurer receives prior approval from the Board. The insurer will assume all liability for maintaining adequate reserves and for paying all claims.

The Board is responsible for establishing a grievance procedure to hear complaints from participants in the plan. The Board is also responsible for conducting a promotion campaign to make employers and employees aware of the plan and to encourage their participation.

Two concepts were included in the legislation to control health care cost inflation: network providers and peer review. Although mandatory components when the bill was drafted as a state-administered plan, the inclusion of these cost containment measures by insurers is now permissive. Originally, it was envisioned that agreements would be reached with a network of health care providers who would provide services for a certain cost and would receive only a portion of their payments for these services. The remainder of the payments would be held in reserve and returned at the end of each fiscal year in proportion to the plan's experience and resources available. Panels of peers would be developed to review the services and charges of physicians and hospitals and to deny payment and suspend providers if charges were excessive.

Employers who elect to provide the state-certified plan for their employees are required by the act to pay fifty percent of the premium attributable to the employee. (They may pay more than this amount and may contribute towards dependent coverage but are not required to do so by the act.) To offset the initial cost of providing this coverage, the employer will receive a tax credit of \$15.00 a month for a two-year period for each employee who participates in the plan. If the employer has no tax liability, the \$15.00 will be refunded to the employer or that amount which is the difference between the tax liability and the tax credit. If the plan can be offered at a monthly premium of \$60.00 and the employer pays fifty percent of that amount or \$30.00 per month, he will receive back

from the state one-half of his expense for providing insurance. In other words, the first two years that the employer provides this coverage, the state will split the cost with him.

I am convinced that Oklahoma has enacted a program which will work. Initial actuarial studies support my belief that a low-cost, basic health benefits plan can be developed. I have faith that an elective program can work if the right product is marketed for the right price and if the incentives are there to purchase the product. SB 346 will enable us to create that product and has put in place incentives which will make it work.

I would be happy to answer any questions that you might have.

An Act

ENROLLED SENATE
BILL NO. 346

BY: FISHER, HENDRICK,
MILES-LaGRANGE, HORNER,
RHODES, SCHUELEIN, BROWN,
DUDLEY, PIERCE, COLE,
GARDENHIRE, WILLIAMS (Penny)
and RUBOTTOM of the SENATE

and

LEWIS, ROSS, WILLIAMS
(Freddie), COX, STOTTEMYRE
and TAYLOR of the HOUSE

AN ACT RELATING TO INSURANCE AND REVENUE AND TAXATION; CREATING THE HEALTH INSURANCE OPPORTUNITIES FOR EMPLOYED UNINSURED OKLAHOMANS ACT; PROVIDING SHORT TITLE; DECLARING PURPOSE; DEFINING TERMS; CREATING THE OKLAHOMA BASIC HEALTH BENEFITS BOARD; REQUIRING BOARD DETERMINE AND APPROVE TERMS AND CONDITIONS OF A STATE-CERTIFIED BASIC HEALTH BENEFITS PLAN; PROVIDING FOR MEMBERSHIP, QUALIFICATIONS, TERMS, VACANCIES, MEETINGS, OFFICERS, TRANSACTION OF BUSINESS, LIABILITY, RULES AND PROCEDURES, STAFF AND REIMBURSEMENT; AUTHORIZING BOARD TO HIRE AN ADMINISTRATOR AND PROVIDING QUALIFICATIONS; STATING POWERS AND DUTIES; AUTHORIZING CONTRACTUAL ARRANGEMENTS; STATING COVERAGE INCLUDED AND EXCLUDED IN PLAN; PROVIDING MINIMUM TERMS FOR PREEXISTING CONDITIONS; STATING PRENATAL CARE COVERAGE; REQUIRING PLAN BE OFFERED TO EMPLOYEES AND DEPENDENTS THROUGH EMPLOYERS; PROHIBITING EVIDENCE OF INSURABILITY AND VARIANCE OF PREMIUMS OR BENEFITS BY AGE; REQUIRING EMPLOYERS PAY CERTAIN PERCENTAGE OF PREMIUM; STATING MINIMUM PARTICIPATION REQUIREMENTS AND DEFINING TERM; REQUIRING PLAN APPLY DIFFERENT TERMS FOR ENTITIES COMPRISED OF TWO INDIVIDUALS OR LESS; PROVIDING FOR RULES TO PREVENT CERTAIN ABUSES; REQUIRING BOARD APPROVE ENTITIES TO ISSUE CERTAIN POLICY OR PLAN; PROHIBITING ISSUERS FROM BEING REQUIRED TO PROVIDE CERTAIN OTHER BENEFITS; REQUIRING COORDINATION OF MARKETING; PROHIBITING REDUCTION OF BENEFITS AND INCREASE IN PREMIUM, FEES OR OTHER CHARGES UNLESS APPROVED BY THE BOARD; ALLOWING BOARD TO DECERTIFY PLAN FOR CERTAIN REASONS AND REQUIRING NOTIFICATION; MAKING ISSUERS LIABLE FOR MAINTAINING ADEQUATE RESERVE FUNDS, CLAIMS PAYMENT AND CERTAIN CONTINUING RISK; CONSTRUING ACT; AUTHORIZING ISSUERS TO DEVELOP AGREEMENTS WITH NETWORK PROVIDERS; ALLOWING ISSUERS TO PROVIDE FOR CERTAIN CONTRIBUTIONS BY AND REIMBURSEMENTS TO NETWORK PROVIDERS; PROVIDING FOR PEER OR UTILIZATION REVIEW; DEFINING TERMS; PROVIDING CERTAIN TAX CREDIT; PROHIBITING GRANTING OF CREDIT UNLESS CERTAIN CONDITION IS MET; AUTHORIZING DEVELOPMENT OF CERTAIN FORMS AND INSTRUCTIONS

AND PROMULGATION OF RULES BY OKLAHOMA TAX
COMMISSION; PROVIDING FOR CODIFICATION;
PROVIDING AN EFFECTIVE DATE; AND DECLARING AN
EMERGENCY.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6501 of Title 36, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Health Insurance Opportunities for Employed Uninsured Oklahomans Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6502 of Title 36, unless there is created a duplication in numbering, reads as follows:

It is hereby declared that the purpose of this act is to:

1. Provide access to adequate health care at an affordable price for Oklahomans who currently lack such access;
2. Increase the number of Oklahomans who have basic medical benefits;
3. Encourage employers to offer and share in the cost of basic medical care benefits; and
4. Limit increases in the cost of health care through competition, effective peer review and provider participation in capitalizing a basic insurance plan.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6503 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Administrator" means the Administrator employed by the Oklahoma Basic Health Benefits Board;
2. "Board" means the Oklahoma Basic Health Benefits Board;
3. "Dependent" means an eligible employee's spouse and unmarried children or stepchildren within age limits and other conditions as determined by the Board with regard to unmarried children or stepchildren;
4. "Eligible employee" means an employee, proprietor or partner who:
 - a. is a resident of this state as defined pursuant to rules promulgated by the Board,
 - b. works an average of twenty-four (24) hours a week or more for an eligible employer, and
 - c. (1) was not covered by a group health insurance policy or plan offered by the same employer within the two (2) months preceding the effective date of

this act and, subsequently, has not been provided such coverage by such employer, or

- (2) was not covered by a group health insurance policy or plan offered by the same employer within the fifteen (15) months preceding the offer to purchase health insurance issued pursuant to this act;

5. "Eligible employer" means a corporation, partnership or proprietorship which:

- a. has done business in this state for at least one (1) year as defined pursuant to rules promulgated by the Board,
 - b. has not provided health insurance:
 - (1) within the two (2) months preceding the effective date of this act and, subsequently, on or after the effective date of this act, or
 - (2) within the fifteen (15) months preceding the offer to purchase health insurance issued pursuant to this act,
- to at least seventy-five percent (75%) of its employees who are residents of this state and work an average of twenty-four (24) hours or more a week for said employer, and
- c. does not violate any rule of the Board promulgated to prevent abuse by parties who form firms primarily for the purpose of qualifying as an eligible employer;

6. "Issuer" means each entity which the Board approves to issue a state-certified, basic health benefits plan; and

7. "State-certified, basic health benefits plan" means the basic health benefits plan developed and approved by the Oklahoma Basic Health Benefits Board pursuant to this act.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6504 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. There is hereby created the Oklahoma Basic Health Benefits Board, to continue until July 1, 1996, in accordance with the provisions of the Oklahoma Sunset Law. The Board shall determine and approve the terms and conditions of a state-certified, basic health benefits plan and provide for the promotion and administration of the plan in accordance with the provisions of this act.

B. The Board shall be composed of eleven (11) members who shall be appointed as follows:

1. One member shall be appointed by the President Pro Tempore of the Senate from an employer or business organization;

2. One member shall be appointed by the Speaker of the House of Representatives from an organization representing employees who lack health insurance; and

3. Nine members shall be appointed by the Governor, subject to confirmation by the Senate, one of whom shall be appointed from each of the following categories:

- a. a physician licensed to practice medicine in this state pursuant to the provisions of Section 481 et seq. of Title 59 of the Oklahoma Statutes and included on a list of nominees provided by the Oklahoma State Medical Association,
- b. an osteopathic physician licensed to practice osteopathic medicine in this state and included on a list of nominees provided by the Oklahoma Osteopathic Association,
- c. a chiropractic physician licensed to practice chiropractic in this state and included on a list of nominees provided by a recognized chiropractic association,
- d. a physical therapist licensed to practice in this state pursuant to the provisions of Section 887.1 et seq. of Title 59 of the Oklahoma Statutes and included on a list of nominees provided by the Oklahoma Chapter of the American Physical Therapy Association,
- e. a hospital administrator or a member of a hospital governing board included on a list of nominees submitted by the Oklahoma Hospital Association,
- f. a state official with responsibilities for delivery of health services,
- g. a state official with responsibilities for administration of purchasing functions,
- h. a person who has professional training and experience in health insurance, and
- i. a person who is licensed to practice law or as a public accountant or a certified public accountant in this state and has experience in fund management.

C. Members of the Board shall serve three-year terms and until their respective successors are appointed and qualified. Provided, of those members initially appointed by the Governor, three members shall serve for one (1) year, three members shall serve for two (2) years and three members shall serve for three (3) years, as designated by the Governor. A vacancy in a position on the Board shall be filled for the unexpired term in the same manner as the original appointment.

D. At the first meeting and annually thereafter, the Board shall elect a chairman, who shall preside over the meetings of the Board and perform such other duties as required by the Board; a vice-chairman, who shall perform the duties of the chairman in the absence of the latter or upon his inability or refusal to act; and a secretary, who shall keep minutes of all meetings and who shall certify to actions of the Board. The Board shall hold regular meetings at least once each quarter and may hold special meetings upon written notice of the chairman or by agreement of any five members of the board.

A majority of the members of the Board shall constitute a quorum for the transaction of business and for taking any official action.

Official action of the Board must have a favorable vote by a majority of the members present. No Board member shall be individually or personally liable for any action of the Board. The Board shall adopt rules and procedures to effectuate its purpose.

The Board shall act in accordance with the provisions of the Oklahoma Open Meeting Act, Section 301 et seq. of Title 25 of the Oklahoma Statutes, the Oklahoma Open Records Act, Section 24A.1 et seq. of Title 51 of the Oklahoma Statutes, and the Administrative Procedures Act, Section 250 et seq. of Title 75 of the Oklahoma Statutes.

E. The Board shall hire an Administrator who shall be in the unclassified service. The Administrator shall have supervisory, managerial or administrative health insurance experience in insurance underwriting, safety or loss prevention, claims management or claims adjustment. The Administrator shall act at the direction of and provide staff support to the Board. Office space and logistical support required by the Board shall be provided by the Office of Public Affairs. The Attorney General shall provide the Board with legal advice and with assistance in drafting rules of the Board.

F. Members of the Board shall serve without compensation but shall be reimbursed for expenses incurred in the performance of their duties in accordance with the State Travel Reimbursement Act, Section 500.1 et seq. of Title 74 of the Oklahoma Statutes. Reimbursement to Board members and any other administrative expenses of the Board shall be paid from the Basic Health Benefits Board Revolving Fund, created pursuant to this act.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6505 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Basic Health Benefits Board shall have the following powers and duties:

1. Provide for the promotion and administration of the state-certified, basic health benefits plan;
2. Determine and approve minimum benefits consistent with the provisions of this act, a policy or contract to be offered and issued under the state-certified, basic health benefits plan, scope of services covered, maximum premium amounts, coinsurance, deductibles, provider payment schedules, and, if appropriate, stop loss provisions, and maximum annual or lifetime benefit amounts;
3. Approve entities to issue the state-certified, basic health benefits plan;
4. Conduct a promotion campaign to acquaint employers and employees with the plan and encourage their participation;
5. Establish a grievance procedure, which shall be in accordance with the provisions of the Oklahoma Administrative Procedures Act, by which complaints of participants in the plan shall be heard;
6. Ensure that all policies or contracts, promotional materials and other printed materials developed and disseminated in connection with the plan are written in plain language and readily understandable by lay citizens of average intelligence who have neither medical nor legal training or expertise; and
7. Publish an annual report which shall include a summary of the costs to the Board to administer and promote the plan, the

participation in the plan by employers and employees and their dependents, the benefits covered under the plan and premiums charged, and tax credits and refunds granted pursuant to this act and a summary of the most recent actuarial analysis of the plan as provided by the issuer. The annual report shall be submitted by February 1 of each year to the Governor, President Pro Tempore of the Senate and the Speaker of the House of Representatives.

B. The Board shall be authorized to contract for:

- a. preparation of plan terms and conditions,
- b. planning and direction of promotion of the plan,
- c. issuance of the plan policy or contract, and
- d. such other functions deemed necessary by the Board to effectively manage its responsibilities.

Contracts with private entities shall be awarded by the Board pursuant to state competitive bidding procedures through the Office of Public Affairs.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6506 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. The Oklahoma Basic Health Benefits Board shall develop a basic health benefits plan which provides coverage for basic hospital and physician care and limited coverage for mental health care, substance abuse treatment and prescription drugs.

2. The plan shall not include coverage for the following:

- a. cosmetic surgery,
- b. chronic fatigue treatment, and
- c. obesity remediation.

B. The plan may include coverage for transplant procedures which shall be limited to kidney, cornea and bone marrow transplants.

C. Except as otherwise provided in this act, at a minimum the plan shall exclude preexisting conditions for the first ninety (90) days of coverage. Subsequently, payments under the plan for treatment of a preexisting condition shall be limited to benefits totalling Five Hundred Dollars (\$500.00) during the first year of coverage, One Thousand Dollars (\$1,000.00) during the second year of coverage and One Thousand Five Hundred Dollars (\$1,500.00) during the third year of coverage. Thereafter, normal policy limits shall apply. The Board may provide for more restrictive terms for exclusions and benefit limits for preexisting conditions.

D. Prenatal care, as defined by the Board, shall be included in the plan and shall not be subject to any deductible, copayment, or exclusion as a preexisting condition. Provided, the Board may limit the maximum dollar amount of coverage for such care.

E. The plan shall be offered to eligible employees and their dependents through eligible employers. Except as otherwise provided in this act, no evidence of insurability shall be required as a condition of coverage under the plan, nor shall the plan vary premiums or benefits according to the age of eligible employees or their dependents. Eligible employers shall be required to pay at

least fifty percent (50%) of the full cost of the portion of the premium attributable to the eligible employee.

F. The plan shall provide minimum participation requirements for each employer which shall be as follows:

<u>Number of Employees</u>	<u>Participation in Plan</u>
3 - 8	100% of employees
9 - 14	all but 1
15 - 18	all but 2
19 - 20	all but 3
21 - 23	all but 4
24 - 25	all but 5
over 25	75% of employees

For purposes of this subsection, "employees" means the employer and eligible employees except for an employer or employee who is covered as a dependent under another group health insurance policy or plan.

G. The plan shall provide for evidence of insurability and may apply underwriting standards, deductibles, copayments, and exclusions for preexisting conditions, as determined by the Board, which are more restrictive than those applied to other eligible employees, for any proprietorship, partnership or corporation which is comprised of two individuals or less. The Board may develop rules to prevent abuse by parties who form firms primarily for the purpose of qualifying as an eligible employer.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6507 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Basic Health Benefits Board shall approve entities to issue a policy or contract under which the state-certified, basic health benefits plan will be offered. Notwithstanding any other provision of law, the issuers shall not be required to provide under said policy or contract benefits other than those approved by the Board. The issuers shall coordinate marketing of the plan with the promotion campaign conducted by the Board.

B. Issuers shall not reduce benefits under the plan without prior approval by the Board. Issuers shall not increase premiums, fees or other charges without prior approval of the Board. The Board may, from time to time, revoke the certification of any state-certified, basic health benefits plan for noncompliance by an issuer with any provisions of this act or rules of the Board. Upon decertification, the issuer shall notify each employer and each policy holder of the revocation of the certification.

C. Issuers shall assume all liability for maintaining adequate reserve funds and for payment of all claims under the plan. Issuers shall assume the liability for continuing risk required by the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended. Nothing in this act shall be construed to constitute a financial obligation or general obligation of the State of Oklahoma nor shall state funds be used to reserve for or pay losses incurred by the issuer.

D. 1. Any issuer may develop agreements with health care providers, to be known as network providers, to provide services under the plan and to receive payment for said services under terms and conditions prescribed by the issuer. The conditions may provide for lower deductibles and copayments for services provided by network providers and for reimbursement to nonnetwork providers who provide services for a patient referred by a network provider.

2. Any issuer may develop agreements with network providers whereby network providers contribute to the capitalization of reserves for the plan. Such agreements may provide that network providers accept provisional payments at a percentage of the allowable reimbursement as set by the issuer and that the balance of the allowable reimbursement be held in reserve until such time the issuer determines that reserves are sufficient to allow additional payments to said providers.

C. Any issuer may develop and administer a system of peer or utilization review for the purpose of reviewing services by and reimbursements to physicians and hospitals.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2357.31 of Title 68, unless there is created a duplication in numbering, reads as follows:

A. As used in this section:

1. "Eligible employer" means a corporation, partnership or proprietorship which:

- a. has done business in this state for at least one (1) year,
- b. has not provided group health insurance:
 - (1) within the two (2) months preceding the effective date of this act and, subsequently, on or after the effective date of this act, or
 - (2) within the fifteen (15) months preceding the offer to purchase group health insurance which meets the requirements of this section,
 to at least seventy-five percent (75%) of its employees who are residents of this state and work an average of twenty-four (24) hours or more a week for said employer,
- c. offers the state-certified, basic health benefits plan to all eligible employees who worked an average of twenty-four (24) hours or more a week during the calendar quarter preceding the purchase of the policy, and
- d. pays fifty percent (50%) or more of the full cost of the portion of the premium attributable to the employee for which the employer is claiming credit;

2. "Eligible employee" means an employee, proprietor or partner of the employer claiming the credit who:

- a. is a resident of this state,

- b. works an average of twenty-four (24) hours a week or more for the employer, and
- c. (1) was not covered by a group health insurance policy or plan offered by the same employer within the two (2) months preceding the effective date of this act and, subsequently, has not been provided such coverage by such employer, or
- (2) was not covered by a group health insurance policy or plan offered by the same employer within the fifteen (15) months preceding the offer to purchase health insurance which meets the requirements of this section; and

3. "State-certified, basic health benefits plan" means the basic health benefits plan developed and approved by the Oklahoma Basic Health Benefits Board.

B. For tax years beginning after December 31, 1990, there shall be allowed to an eligible employer a credit against the tax imposed by Section 2355 of Title 68 of the Oklahoma Statutes for premiums paid on behalf of each eligible employee who elects to participate in the state-certified, basic health benefits plan and meets the requirements of this section. The credit shall be in the amount of Fifteen Dollars (\$15.00) a month for each eligible employee and shall be allowed for two (2) consecutive tax years. Provided, if the tax liability of an employer pursuant to Section 2355 of Title 68 of the Oklahoma Statutes is less than the credit to which the employer is entitled pursuant to this section, the Oklahoma Tax Commission shall pay a refund to the employer. The refund shall equal the difference between the amount of taxes owed, after any other credits or exemptions to which the employer is entitled have been applied to the tax liability, and the credit to which the employer is entitled pursuant to this section for the tax year.

C. The credit shall not be granted unless the eligible employer certifies to the Oklahoma Tax Commission that each employee for which the credit is claimed is participating in the state-certified, basic health benefits plan.

D. The Oklahoma Tax Commission shall develop and issue appropriate forms and instructions to enable eligible employers to claim the tax credit. The Commission shall promulgate rules to facilitate the implementation of this section.

SECTION 9. This act shall become effective July 1, 1990.

SECTION 10. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the Senate the 25th day of May, 1990.

ACTING Herb Rogell
President of the Senate

Passed the House of Representatives the 25th day of May, 1990.

Jim R. Glover
Speaker PRO TEMPORE of the House of
Representatives

OFFICE OF THE GOVERNOR

Received by the Governor this 25th
day of May, 1990
at 6:45 o'clock P M.

By: Mary Alexander

Approved by the Governor of the State of Oklahoma the 31st day of
May, 1990, at 6:00 o'clock P M.

Henry Bellmon
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Secretary of State this
1st day of June, 1990
at 9:40 o'clock A M.

By: Bruce T. Felt

**TESTIMONY
OF THE
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
ON**

**States' Efforts to Increase the Availability and
Affordability of Health Insurance
For Small Businesses**

**BEFORE THE
UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON SMALL BUSINESS
SUBCOMMITTEE ON ANTITRUST, IMPACT OF
DEREGULATION, AND PRIVATIZATION**

**The Honorable David Lyons
Acting Commissioner
Iowa Department of Insurance
August 10, 1990**

Mr. Chairman and members of the Subcommittee, thank you for this opportunity to discuss the problems faced by small businesses and their employees in gaining access to adequate and affordable health insurance coverage.

My name is David Lyons and I am the acting Commissioner of Insurance in the State of Iowa. I am here today representing the National Association of Insurance Commissioners ("NAIC"), which is a nonprofit association whose members are the insurance officials of each state, the District of Columbia, Guam, American Samoa, Puerto Rico and the Virgin Islands.

The purpose of my testimony is to describe the activities the NAIC is undertaking to improve access to health insurance coverage for small businesses and their employees. These activities attempt to address three critical issues: correcting abusive rating practices; improving continuity of coverage for both groups and members of groups; and, assuring availability of coverage for all small businesses (regardless of employee health status) through a reinsurance pooling mechanism. We anticipate that a model bill addressing abusive rating practices and renewability of coverage will be adopted by the NAIC at its winter meeting this December. The preliminary results of NAIC's study of the potential of a reinsurance pooling mechanism to

improve availability of coverage should also be ready for distribution at the December meeting.

In discussing these efforts, however, a caveat is necessary: addressing abusive rating practices and availability of coverage concerns will not necessarily bring down the ultimate cost of health insurance for small businesses. The costs of insurance primarily reflect the costs of health care services, which continue to soar. We believe that our efforts will produce an insurance market for small businesses that is fairer, more accessible, easier to understand, and more predictable. Addressing the critical issues surrounding affordability of coverage, however, will require a much broader societal effort.

A. Rating and Renewal Practices

(1) Current Practices.

Recently, state insurance regulators have received increasing numbers of complaints from small employers about practices in the health insurance market. Large rate increases (sometimes over 200 percent) and refusals to renew coverage are frequently cited problems.

Premiums for small group health insurance are largely determined through competition; only a few states directly

approve premiums charged to small businesses. In recent years, insurers have begun competing for businesses by offering low rates in early years and "building in" rate increases if the group continues with the insurer. This is called "durational rating". Low initial rates are possible because insurers medically underwrite (use health screening) to assure that the group is healthy before they accept it for coverage. A healthy group will generally produce lower than average claims experience, so the insurer can charge lower rates initially. However, the benefit of health underwriting "wears off" after two or three years (some employees will become sick or have accidents), requiring the insurer to raise rates to fund the predictable increase in claims.

Insurers also are increasingly using claims experience and/or health status to determine rates in this market. Because initial rates are low, insurers, on average, need to raise rates for groups that continue with the insurer. However, if the insurer builds-in rate increases for all groups, the healthier groups (who can pass medical underwriting with another carrier) will move to another insurer to keep a low initial rate. In response, insurers have developed "tier rating". In tier rating, the claims experience of a group is used to select its premium level at renewal. Insurers increase rates more for groups with poor claims experience (e.g., high claims frequency, employees with serious or expensive illnesses). In some cases these rate

increases have been extremely high.

In many cases, insurers also can choose not to renew coverage for a group. For example, an insurer may choose to nonrenew or terminate a group because it has poor claims experience or because an employee or dependent has developed a serious medical problem or disability. Groups terminated for these reasons will have a hard time finding replacement coverage because they will be unable to meet insurer medical underwriting standards.

As increasing health care costs gradually erode the affordability of coverage for small businesses, the problems inherent with these rating practices become exacerbated. Price competition to produce the lowest rate for new business appears to be causing more aggressive use of these rating practices. Groups with higher claims experience are more and more experiencing large premium increases or, sometimes, termination. In some cases, these groups can and do reduce their costs by dropping a sick employee from the group, leaving that employee uninsured and sometimes uninsurable. The market's focus has shifted away from long-term sharing of risk across a relatively large number of groups and towards providing a low short-term price to select groups.

(2) Development of NAIC Model Legislation

In response to these problems, the NAIC has formed a task force of insurance regulators to develop model legislation addressing the rating and renewal practices in this marketplace. The task force now is considering the recommendations of an industry advisory committee and plans to circulate draft model legislation for comment early next month. Final adoption of a model bill is scheduled for the NAIC's December meeting.

The task force is currently considering legislation that would accomplish three important goals relating to rating and renewal practices: (1) requiring increased disclosure to consumers of insurer rating methods; (2) placing limits on certain rating practices and requiring actuarial certification of rating methods; and (3) limiting significantly an insurer's ability to terminate or nonrenew a group's coverage.

The first step in reforming rating practices is to ensure that small business consumers thoroughly understand how their rates are being determined. The NAIC task force currently is considering a requirement that insurers disclose the following information at the time of purchase: the insurer's right to change rates; any factors, including the group's claims experience, health status, or duration of coverage, that could affect the group's rates; the class (or block) of business the

group would be placed into; and, the conditions that affect renewability of coverage. Disclosure of these factors should enable small businesses to make more informed purchases of group coverage and to better understand how their rates may change at renewal.

The second, and most significant, step being taken by the task force is placing limitations on current rating practices. The task force is currently considering a three-prong limit on rates: (1) within any class (or block)¹ of small group business, rates could vary by no more than 25% around the midpoint; (2) for all classes of business, the midpoint rate of any class could not be more than 20% higher than the lowest-rated class of business; and (3) in any year, the maximum increase that an employer could receive would be equal to the change in the rate for new business in that class plus 15%. Insurers would be permitted to apply to the insurance commissioner for a waiver of the 20% band around classes of business.

Essentially, in any year, the maximum change in rate that could be attributable to a group's health status, claims experience or duration of coverage would be 15%. Otherwise, the

¹ Insurers use separate "classes" or "blocks" of business to distinguish different groups of business that should produce different results. The factors being contemplated by the task force for defining "class" include business that is insured through or for a bona fide association, business marketed through a different method of distribution (e.g., agent sold or direct marketed), and a class acquired from another carrier.

annual rate change would be based primarily on the change in rate for new business -- which should reflect the trend in health care costs and utilization. The new business rate was chosen as an index because insurers are heavily penalized if they cheat: if they raise it too much they would be uncompetitive for new business; if they keep it too low, they would be underpricing the entire class and incur significant losses.

The overall rate bands described above are designed to assure that rates will not vary excessively within a class of business or within the insurer's entire book of small group business. The model under consideration would permit some variation in the rates of an insurer (if based on actuarially sound rating principles), but its enactment would significantly compress the degree of rate variation that currently exists.

In addition, the task force is considering a requirement that each insurer keep on file for examination a detailed description (including documentation) of the insurer's rating methodology and underwriting practices. In addition, each insurer would be required to file an annual actuarial certification that the insurer's rating methods are based on sound actuarial principles. We believe that these requirements would improve the ability of insurance regulators to monitor the rating practices of insurers and enforce the limits on rating practices described above.

The third step being taken by the task force is to significantly limit the ability of insurers to terminate or not renew coverage. The task force is considering renewability provisions which would: (1) generally prohibit termination or nonrenewal by the insurer of individuals or dependents within a group; (2) generally prohibit the termination or nonrenewal by the insurer of groups within a class of business; and (3) permit termination of a class of business only upon notice to the groups and to the commissioner.² An insurer that cancels a class would be prohibited from starting business for a new class for a period of five years.

We believe that these provisions would go a long way toward guaranteeing continuity of coverage for small businesses and their employees. Termination or nonrenewal of specific groups or individuals is generally prohibited. Further, the penalty for terminating an entire class (i.e., prohibition against writing new classes of business for five years) should discourage termination except in the most extreme cases where the insurer is unable to continue to provide coverage or is leaving this market altogether.

² Termination or nonrenewal also would be permitted in cases of fraud, failure to abide by provisions of the contract, or if the small employer is no longer engaged in business.

B. Improving Availability Through Reinsurance Pooling

In conjunction with its work on rating and renewal practices, the NAIC is also investigating ways to guarantee availability of health insurance coverage to all small groups, regardless of the health status of their employees and dependents. Currently, in order to protect themselves against adverse selection,³ insurers medically underwrite small groups before accepting them. Groups that have sick or disabled employees or dependents often find it extremely difficult or impossible to get health insurance. Sometimes these groups deliberately exclude the sick individual from the group plan in order to obtain coverage for the remainder of the group. In addition, some insurers refuse to write coverage for groups in certain professions or occupations that they consider higher risk.

Following the example of legislation enacted in Connecticut and under consideration in California, the NAIC is considering the development of a model reinsurance pooling approach that would allow the marketplace to provide coverage to any group. Although there are many possible variations and an abundance of issues to be worked out, in concept, a reinsurance pool for small

³ Adverse selection is the tendency of individuals with higher risk of loss to preferentially seek coverage.

group business is a method to require most or all the insurers who provide small group coverage to equitably share the costs attributable to high-risk individuals and groups insured in the market. Under such an approach, insurers can choose to reinsure high-risk individuals or groups (under set rules and premiums) with the reinsurance pool. The group will be charged a premium that is somewhat higher than average, but in most cases substantially lower than the premium needed to cover the group's losses. The extra costs are spread throughout the market through the reinsurance pool.

The goal is to assure that individuals and groups are not denied needed coverage because of health problems. However, as we noted above, efforts such as these to guarantee availability of coverage will not lower the ultimate cost of health care coverage. Indeed, by providing access to higher risk groups and spreading the costs throughout the marketplace, health insurance premiums may increase (the increase should be slight). Again, the critical problem of affordability must be addressed by a broader societal effort.

C. Other Continuity of Coverage Issues

In addition to the renewability provisions discussed above, the NAIC task force is considering other measures to assure continuity of coverage, such as (1) requiring insurers to insure

all eligible employees and dependents of a group; (2) requiring an insurer replacing group coverage to insure all employees and dependents that were previously insured; and (3) prohibiting insurers from assessing new waiting periods or preexisting condition exclusion periods when groups change carriers or when insured individuals change employers. Such provisions are important to prevent lapses in coverage and denial of coverage to certain group members because of their health status. The state of Maine adopted provisions similar to these earlier this year.

Provisions such as these need to be considered on their own merit and as part of a reinsurance pooling approach. With a reinsurance pool, continuity requirements are easier because insurers can spread their risk of adverse selection across the entire market.

D. Other NAIC and State Activities

State insurance regulators are involved in many other activities that affect the small business health insurance market. One area of greatly increased activity is regulation of multiple employer welfare arrangements, or MEWAs. In some states, self-funded MEWAs have sprung up to provide coverage to small businesses at bargain basement prices, only to fold because of inexperience or pure fraud. Often these entities are created

and marketed by entrepreneurs who wrongly claim that ERISA⁴ exempts them from state regulation. Individuals commonly receive large fees for marketing and administering these MEWAs. Because they claim exemption from state regulation, state regulators often do not find out that a MEWA is operating until they stop paying claims and the businesses begin to complain.

In the past year, state regulators, in conjunction with the NAIC, have taken significant steps to help protect small businesses from fraudulent self-funded MEWAs. Lines of communication between state regulators and the federal Department of Labor, which has jurisdiction over ERISA enforcement, have improved and efforts are underway to identify self-funded MEWAs. An NAIC task force has produced a workbook for states to assist them in pursuing MEWAs claiming federal preemption of state laws. The NAIC also has begun a computer data base, available to all states, to permit regulators to share information about individuals and entities of special regulatory concern, including MEWAs. While these activities have not solved all of the problems with self-funded MEWAs -- some changes to federal legislation may be needed -- we believe that substantial progress has been made.

Finally, state insurance regulators in a number of states have been involved with special laws or programs to assist small

⁴ The Employee Retirement Income Security Act of 1974.

businesses to gain access to health insurance. For example, several states, including Florida and Washington, have passed laws limiting the applicability of state mandated health benefit laws to small group insurance. The goal of these laws is to provide basic, lower cost insurance options for small businesses and their employees. We would appreciate the opportunity to submit further examples of different state approaches for the record.

E. Conclusion

The NAIC appreciates the opportunity to participate in this vital inquiry into methods to increase the availability and affordability of health insurance for small businesses and their employees. As insurance regulators, we feel that our role is to regulate the insurance marketplace so that it operates fairly and efficiently to provide coverage to the broadest possible group of individuals. We believe that the initiatives being undertaken by the NAIC are consistent with that role. Thank you again for inviting the NAIC to testify here today, and I would be pleased to answer any questions you may have.

Testimony of the Oklahoma
Insurance Department before the
United States House of Representatives
Committee on Small Business,
Subcommittee on Antitrust, Impact of
Deregulation, and Privatization

Summary

(A) Efforts to increase the availability of health insurance in Oklahoma:

- (1) Insurers are designing innovative health insurance products for the small business market.
 - (i) Blue Cross and Blue Shield of Oklahoma's "Basic" plan
 - (ii) PPO riders
- (2) Oklahoma has enacted statutes to increase the availability of health insurance and protect the employees.
 - (i) 36 O.S. § 4501(3)
 - (ii) 36 O.S. § 4509.1
 - (iii) 36 O.S. § 4509
- (3) The Insurance Department has given priority to the admission of insurers writing health insurance.
- (4) The Insurance Department has employed a market conduct examiner.
- (5) The Insurance Department has proposed legislation to regulate Multiple Employer Welfare Arrangements.
- (6) Oklahoma has passed legislation encouraging employers to offer health insurance through the use of incentives to the employer and the insurer.

(B) General problem of rising costs in the health insurance industry:

- (1) Higher rates have resulted from a combination of medical inflation, a sluggish economy, and increased utilization of medical services.
- (2) Insureds are therefore experiencing longer and more frequent rate increases.
- (3) As a result, employers are turning to alternate methods of covering their health care.

Testimony before the United States
House of Representatives Small Business
Subcommittee on Antitrust, Impact of
Deregulation and Privatization, by
the Oklahoma Insurance Department

The Oklahoma Insurance Department appreciates the opportunity to appear before your subcommittee to discuss the availability, and the rising costs, of health insurance for small businesses in Oklahoma. Our concern is not only whether or not coverage is available, but also the quality of that coverage. Too often, poor coverage ends up being no coverage through the liquidation of the insurer, collapse of the trust or just the rise in the premium beyond the point of affordability.

In a tough market, Oklahoma insurers have been making efforts to increase the availability of health insurance coverage in our state. Our department has approved innovative health insurance products which specifically address the needs of the small business market.

One example is the Blue Cross/Blue Shield of Oklahoma "Basic" plan. This program has been designed to be affordable for self-employed individuals, part-time employees, and small businesses. It offers a basic level of benefits, while still covering all of our Oklahoma mandated benefits, plus pre-natal and maternity care, well-baby

care and mental health care.

In the last few years we have also approved health insurance contracts which contain PPO riders. PPO stands for "preferred provider organization". These riders allow an insured to choose from a list of doctors who have agreed to discount their fee to the insurer. This allows the insurer to pass the savings directly onto the insured by waiving deductibles and/or co-payments. It also allows the insurer to more carefully monitor utilization of health care services.

Our department has been involved in the passage of several statutes designed to increase the availability of health insurance and protect the insured. Our group accident and health statutes were amended to allow employers in different industries to establish a policy. Previously, only employers in the same industry could receive a group health policy.

Oklahoma passed a law in 1988 which was written to protect employees in groups of ten or more from losing their benefits when their group coverage was replaced by another carrier. It was designed to prevent gaps in coverage from occurring due to new pre-existing condition periods and deductibles.

We also have a law which requires a 30 day extension of coverage for employees whose insurance is terminated for any reason,

including gross misconduct. We require at least a three month extension of benefits for employees who are totally disabled or under a continuous plan of surgical treatment, which shall include maternity expenses. COBRA extensions are only available to groups of 20 or more, so our law offers some protection to smaller groups.

Our financial division has given a priority to the admission of companies who will write accident and health insurance in Oklahoma. As a result, we have admitted approximately 12 companies in the past year who will write health insurance in Oklahoma.

Our department is very concerned about the treatment of our insureds. As a result, we have employed a full-time market conduct examiner to review the marketing, underwriting, and claims-paying practices of our life and health insurers. This will help guarantee that insurers are complying with Oklahoma law and are treating our insureds fairly.

As a result of concerns over the quality of coverage offered by Multiple Employer Welfare Arrangements, our department attempted to pass legislation in 1990 to regulate these plans. Our proposed law would have required these plans to be fully underwritten by an insurer, unless they could prove their status as an ERISA or VEBA plan, subject to federal jurisdiction.

Our department was involved in recent legislation which will encourage employers to offer health insurance to their employees by providing a tax credit to the employer. Senate Bill 346 provides for approval of health plans which will not have to comply with mandated benefits and will not be allowed to underwrite the group. This will hopefully make health coverage more affordable and more available for small businesses.

Our department's hope is that the effect of all of these actions will serve to increase the availability of health insurance, without turning our back on the quality of the coverage being offered.

In the past few years we have become very aware of the effect rising costs in the health insurance industry have had on Oklahoma insureds and on the financial stability of the insurers. We have placed Oklahoma health insurers into liquidation as a result of unprofitable group health business. We realize that for insurers to remain active in the market, they must be able to make a profit on the risks they assume.

Several factors appear to be contributing to the rising cost of health insurance. Insurers must contend with medical inflation, a sluggish economy, and increased utilization of health care services.

In Oklahoma, we have seen insurers increase their rates as frequently as every six months on group health insurance. In order not to drive off their healthy risks, insurers have sometimes turned to "experience" or "tier" rating. This allows the insurer to assess a portion of an employer's rate increase based on that employer's experience. Although this may have served to keep healthy risks insured, it has disastrous effects on those small employers who have had the misfortune of an employee being stricken by a serious illness. We have seen rates as high as \$ 900.00 per month for an individual. With premiums this high, it is not only the indigent who are unable to afford health insurance.

As a result many small companies are turning away from traditional insurance to alternate methods of coverage. In some instances this has allowed the unwary to be preyed upon by the unscrupulous. Without an authorized insurer fully underwriting a plan, there is no Insurance Department regulation, and no Guaranty Fund protection in the event of insolvency of the plan.

These are some of the problems we have seen and attempted solutions in which we have participated. We feel these actions have increased the availability and quality of health insurance for small businesses. However, an insurance policy is not an answer for those employees and employers who can not afford health insurance and for those whose health history makes them an unacceptable risk for an insurer to accept. Not all of the working

uninsured are able to afford health coverage if it is available, and certainly some will never be able to meet underwriting requirements due to their health. For those employees and employers other solutions are needed.

SMALL BUSINESS SUBCOMMITTEE ON ANTITRUST, IMPACT
OF DEREGULATION AND PRIVATIZATION

Hearing on Friday, August 10, 1990, at 9:30 a.m. in the
Aaronson Auditorium, Tulsa City/County Public Library,
Tulsa, Oklahoma.

Testimony of W.R. Horkey:

8801 S. Yale, Suite 240
Tulsa, Oklahoma 74107
918-496-2425
Fax 918-496-8637

Retired Executive Vice President, Helmerich & Payne, Inc.;
President, Tulsa Business Health Group, Inc.; President,
Tulsa Community Foundation for Indigent Health Care, Inc.;
Vice Chairman, Oklahoma Council on Health Care Delivery.

SUMMARY

Private industry can offer comprehensive medical coverage that small businesses will buy. Tulsa Health Option (T.H.O.) provides medical coverage to small businesses in Tulsa. T.H.O. requires support from community leaders. A managed care, provider-at-risk, program offers a means of restraining growth in cost of medical services.

The State of Oklahoma created the Oklahoma Council on Health Care Delivery which was directed to look at the employed uninsured population of the state. The Council recommended specific legislation to: provide uniform statewide data collection; establish state sponsored "risk pools" for the medically uninsurable; and, enact the Health Insurance Opportunities for Employed Uninsured Oklahoma Act. Most importantly, the Council urged a "comprehensive approach" which addressed: broader Medicaid qualifications and service cost reimbursements; underfunded Medicare; insurance for the medically uninsurable; and insurance for both the employed uninsured and underinsured and the unemployed uninsured. The Council recommended an Oregon type rationing approach with citizen input, and legislative decision making.

Tulsa Health Option (T.H.O.), a medical insurance program for small businesses, is demonstrable proof that private initiative can provide affordable insurance for small businesses and that small business employers will make such insurance available to their employees. T.H.O. offers a managed care coverage through an alternative delivery system (originally a Preferred Provider Organization "P.P.O." and a Health Maintenance Organization "H.M.O.", now only an H.M.O.). T.H.O. is the product of a joint undertaking by business, labor, insurers, health care providers, and local government through a grant from the Community Program for Affordable Health Care of the Robert Wood Johnson Foundation. T.H.O. is marketed through and endorsed by the Metropolitan Tulsa Chamber of Commerce.

After three (3) years of experience with T.H.O. we believe that we have validated certain of our initial heretic assumptions and made other valuable observations.

T.H.O. Assumptions: (1) Employees of small businesses are not sicker than employees of large businesses; i.e. 10 employees of 100 employers represent the same actuarial risk as 1,000 employees of 1 employer. In fact, after a two (2) year period, the H.M.O. provider found that it had a lower per capita cost for the small business enrollees than for its traditional large business enrollees. (2) Small business employers are just as motivated to provide and as

desirous of providing health care benefits for their employees as are large businesses. A survey of small business members of the Metropolitan Tulsa Chamber of Commerce revealed a high level of interest to purchase a reasonably priced comprehensive medical benefits coverage. T.H.O. has achieved an enrollment of 10% of its estimated market. Dr. Ewe Reinhardt, the Princeton University medical economist, estimates that at best, only one-third (1/3) of the employed uninsured can afford to purchase medical insurance. In addition to our measurable market penetration, we are aware that insurance providers were suddenly attracted to our proven market. There are now at least five (5) indemnity plan insurers specializing in medical insurance for small employers who are actively selling in the Tulsa market. We currently have no mechanism for measuring their market share. Does T.H.O.'s 10% make a real difference? We estimate that T.H.O. coverage provided approximately \$6,000,000 of care annually, which would otherwise have been cost shifted to large business employers and private pay patients. Over time we anticipate continued market penetration for T.H.O. We continue educational efforts to increase enrollment and word-of-mouth success stories are effective sales motivators.

T.H.O. Observations: (1) Large business employers are not devoid of social consciences. Besides, in this case there really is "something in it for them." As an inducement to a willing T.H.O. provider, Tulsa Business Health

Group, Inc. (T.B.H.G.) members agreed to open the access doors to their benefits managers and permit such provider(s) to market the T.H.O. product to the employees of the large businesses with management endorsement. In addition, several large employers contributed a portion of premium dollar savings to a risk pool as an initial cushion against an unknown, uncertain risk. Fortunately, the risk pool was not needed. The payback to large employers -- We estimate that the large employers in Tulsa save about \$15.00 per employee per annum because of T.H.O. enrollment by way of avoided cost shift. (2) T.H.O. is more easily adaptable to urban situations. Alternative Delivery Systems (A.D.S.) networks are much easier to establish in cities where large group practices already exist and are a part of the community medical culture. Referral patterns are established in cities and tertiary care hospitals facilitate care delivery. Ease of access to the system providers by patients in cities and span of control of practice styles in cities are not the same as in rural areas where some system of regional delivery must be established. (3) "Don't kill the goose who lays the golden egg." These words of wisdom were passed on to us pre-Robert Wood Johnson Foundation grant by a seasoned Blue Cross Blue Shield executive. They are critical to success. In spite of our smugness about T.H.O. Assumption (1) there are actuarial minefields which are very real. The medically uninsurables in any given population represent an enormous cost that no one insurance

carrier or program can afford. No small business medical insurance program can begin to assume this risk. As of today, the State of Oklahoma can't or won't assume this risk for its citizens. Therefore, reasonable health screenings or pre-existing condition claims limitations are a sine qua non for any small business coverage program over the long term. Requiring the carrier or provider to take all applicants, especially one (1) employee businesses, without medical screening, is not only foolhardy, but also certain to eventually kill the "golden goose." (4) T.H.O., as a model program for medical coverage for the employed uninsured is not the end solution to medical care cost containment. It helps. It avoids some cost shifting. It does not address Dr Ewe Reinhardt's two-thirds (2/3) of the employed uninsured who can't afford to buy even when the insurance is available. It does not address those unemployed uninsured who may nationally equal in numbers the employed uninsured, but in Oklahoma are believed to be approximately 16% of the employed uninsured. (5) Prepaid, capitated, or provider at risk A.D.S.'s will contain health care costs and provide quality health care. They work for business. They will work for true charity patients, medicare and medicaid patients. So, why do we continue fee for service (translate - cost plus) reimbursement programs for charity and government program patients? As Dr. Reinhardt said, our national health policy, or lack thereof, reflects a deep-seated mental chaos on the matter of distributive justice. (6) Small

business health plans should be community rated. They in fact have higher marketing costs per employer and higher administrative costs per employee than do large business health plans. Age rating across a twenty-five (25) or less employee group can price some employers out of the market. Competition among providers can lead to savings by reducing profit margins. Competition for sales to employers with fortuitous short term experience at reduced rates can price other employers out of the market. Under-pricing plans to gain market share ultimately leads only to more cost shifting.

How do you create a T.H.O.? You start with a group of businesses who are noted for being on the cutting edge of community leadership in all areas, be it community image, education, cultural programs, charities, or social concerns. You add leaders from insurance, government, labor, and health care providers. Cooperatively, you design a model benefits plan. You request a proposal (R.F.P.) process from insurers and providers. You modify your benefits plan to accommodate a price at which there will be buyers. You do not sacrifice adequacy of coverage or quality, otherwise you defeat your purposes. Once the plan is defined, the providers are chosen, and the prices are fixed, you embark on a truly community-wide effort to educate the public regarding the plan and to market it. Once underway, you continue to survey and audit for perceived customer satisfaction, quality of care, and reasonableness of pricing.

The Oklahoma Council on Health Care Delivery was created by state statute some two (2) years ago. It delivered its final report at the end of June, 1990. The printed report was made available for general distribution on August 3, 1990. The Council was directed to study the incidence of medical indigence in Oklahoma, health care delivery alternatives (especially to the medically indigent), and funding methods and resources. In an effort to not reinvent the wheel, careful attention was paid to programs in the States of Arizona, Colorado, and Oregon.

As anyone who has tried to grasp the magnitude of the medically indigent problem well knows, you are starved by the dearth of meaningful statistical data and drowned in the plethora of meaningless or unintelligible numbers. You are also confused, misled, and dazzled by the "Alice-in-Wonderland" accounting terminology and buzz word terminology of the health care industry; e.g. billed charges and uncompensated care. To alleviate this situation the Council recommended legislation to create the Oklahoma Health Care Information Act, which languished in committee during the recently adjourned legislative session. This proposed legislation defined contractual adjustments, bad debts, charity care, and other deductions from revenue in order to get a handle on "Uncompensated Care." It also would mandate use of U.B. 82's for all hospital reporting purposes to the State of Oklahoma.

I have earlier in the T.H.O. section referred to the magnitude of the medically uninsurable problem. The Council endorsed the enactment of "risk pool" legislation, acknowledging this to be a statewide problem and the State's responsibility to fund on the broadest base tax possible.

The Council created a Working Uninsured Committee to determine the feasibility of an insurance program for the employed uninsured. This Committee recognized the problems, as discussed in T.H.O. observation (2), of expanding the T.H.O. concept in a basically rural state, such as Oklahoma. The Council endorsed the Health Insurance Opportunities for Employed Uninsured Oklahomans Act, Senate Bill No. 346, effective July 1, 1990. It was pleased with the subsidy features through state income tax credits; the emphasis on affordability, managed care, and risk on providers and private carriers. But as stated in T.H.O. Observation (4), this is only going to get at a portion of the uninsured population be they employed or unemployed. The service industry is the fastest growing industry segment in Oklahoma with respect to employment and earnings growth. Twenty-one percent (21%) of employee earnings in Oklahoma in 1988 came from the service sector. Service and retail trade industries have the lowest pay scales compared to other components of the labor market. Service and retail trade represent Forty-seven percent (47%) of Oklahoma's total wage and salary employment. They represent the highest number of working uninsured in Oklahoma. Therefore, the Committee recommended and the Council ul-

timately reported to the State that lasting solutions would only occur when government and the public addressed the entire problem of "distributive justice" with regard to medical care.

The plain fact of the matter is that the present health care delivery system has an insatiable appetite for ever increasing amounts of money. To paraphrase a Peter Principle - Medical services will increase to meet the money available to pay for them. This is not intended to be finger pointing or blame fixing. It is fact that the aging population (demographics) will consume proportionately more health care services. It is highly probable that ongoing development of new medical technologies will expand diagnosis and treatment options. As Joseph Wassersug, M.D. has stated: "Physicians and hospitals have, through a too successful marketing campaign, created market perceived health care needs that don't really exist." There is increasing concern over the appropriateness and necessity of services being rendered. Robert Brook of Rand Corporation says that in case after case a doctor can perform a \$100 procedure or a \$10,000 procedure with no difference in outcome. One third (1/3) of carotid endarterectomies yield no medical benefit and another one third (1/3) provide questionable medical benefits. One third (1/3) of open heart surgeries are not medically necessary. Twenty-five percent (25%) of babies born in 1987 were delivered by caesarean section. Fifty percent (50%) of these C-section deliveries were medically

unnecessary. Why are there more Caesarean Sections among the insured population than among the uninsured and public aid patients? Surely observations such as these cry out in support of more standardized treatment protocols. For reasons such as these, the Council has recommended to the Governor and both houses of the legislature that the State of Oklahoma embark upon an Oregon style discussion of rationing, with "distributive justice" and recognition of costs and who pays, in lieu of the present de facto rationing by denial of services, draconian mazes of system entry and the hidden taxes of cost shifting. We are primarily discussing in this hearing the matter of who gets what services and who pays for them and how. For the most part, we are discussing health care services which are being delivered and are being paid for by someone. We are not at this time discussing denial of services which most assuredly does occur (without good statistical support). Given a structured rationing system, we will know who does not get what services and for how much cost savings (?). Cost shifting is an insidious highly efficient method of hidden taxation. It does not lead to "distributive justice." The end result of cost shifting is that the weakest and least able to pay end up with the largest burden.

Health care system aphorisms: (1) If I do it to you, it is cost sharing. If you do it to me, it is cost shifting. (2) Working teenagers and lower twenties are immortal.

They have no need for health insurance in their own minds.

(3) There is no free lunch. (4) Someone has to pay the piper.

Phil Watson

Director, Oklahoma Department of Human Services
Chairman, Oklahoma Council on Health Care Delivery

Testimony Before the Subcommittee on Antitrust
Impact of Deregulation and Privatization

August 10, 1990

Tulsa, Oklahoma

Phil Watson, Director

Oklahoma Department of Human Services

Chairman, Oklahoma Council on Health Care Delivery

H.B. 1451, Section 66.2 of Title 56, Oklahoma Statutes created the Oklahoma Council on Health Care Delivery for the purpose of conducting a study of the incidence of medical indigence in Oklahoma, health care delivery alternatives for all Oklahomans, especially the medically indigent, which are both cost- and service-effective, and funding methods and resources for these services. The Council was directed to make recommendations relative to health insurance programs for the employed uninsured, the medically uninsurable and alternative health care delivery systems to serve the Medicaid population.

The legislation specifically directed the Council to determine the feasibility of a health insurance program which is to be subsidized by the State of Oklahoma and made available to persons who are ineligible for other public health insurance programs, not covered by their employer and cannot afford to purchase private care or insurance.

Before addressing the Council's recommendations, it is important to understand the magnitude of the problem relative to the uninsured population in Oklahoma.

According to studies completed by the Benefit Research Institute and subsequent studies by the Center of Health Policy Research - Oklahoma Medical Research Foundation, Oklahoma has one of the highest rates of citizens without health insurance in the nation. In 1986, the most recent data available, Oklahoma ranked 8th in the nation in the number of citizens without health insurance. It is estimated that nearly 637,000 non-elderly Oklahomans lack health insurance. Of this total, it is estimated 536,000 are employed or dependents of employed persons representing 84 percent of the total uninsured population in Oklahoma. Further analysis of the data indicates that nearly 60 percent of the working uninsured, including their dependents, are employed by business establishments that employ less than 20 employees. According to Oklahoma Employment Security Commission data, nearly 41 percent of Oklahoma's non-agricultural and salary workers are employed in the retail and service industries. Typically, these industries have lower pay scales than other segments of industry and are less likely to provide health benefits. Data from the Center of Health Policy Research - Oklahoma Medical Research Foundation study estimates nearly 50 percent of the total persons employed in the retail and service industries were uninsured.

Why are there so many uninsured Oklahomans? There are a number of factors that influence the availability of health insurance. No doubt the economic decline during the 1980s had a significant impact. The ratio of Oklahoma's per capita personal income to that of the U.S. declined from 99 percent in 1982 to 81 percent in 1988.

The cost of health insurance is a major barrier to providing coverage to employees, particularly small employers. Insurance is a complex issue and is influenced by a number of factors. While we have no data to support the increase in health insurance premiums in Oklahoma in the last few years, we do believe that Oklahoma is not much different than what is happening nationally. One study shows that over the last eight years the average premium increase for American businesses has increased 17 percent. In 1989, employer-based insurance premiums increased 20.4 percent and premiums are forecasted to increase 23 percent in 1990.

The cost of health services and mandated benefits are often cited as reasons for increased premiums. As you are aware, the cost of health care is a major problem that affects both affordability and access to health care. The national health care bill is approaching \$600 billion annually. The health care component of the GPI is nearly double that of the general inflation rate. Again, we think Oklahoma is not that much different than the nation. Previous studies have shown that Oklahoma usually follows national trends in health care costs and that health care expenditures consume a significant portion of the gross state product.

Another area that the Council expressed concern over was the cost shift and its effects on the cost of health services and insurance premiums. In 1988, Oklahoma's general acute hospitals reported they wrote off \$682 million in uncompensated care. Contractual adjustments for the Medicare and Medicaid programs and other contractual agreements accounted for the major portion of this amount. Hospital write-offs for bad debts and charity care totaled nearly \$184 million. While write-offs for bad debts and charity appear to be relatively insignificant when compared to the write-offs for contractual adjustment, they do represent a significant amount of dollars and the amounts are growing. Write-offs for hospital bad debts and charity increased nearly 11 percent in 1988 over that reported the previous year.

The impact of high premiums on the affordability of health insurance may be best illustrated by a study prepared by the National Health Care Campaign, Washington, D.C. This group did a study for Oklahoma on the affordability of Health Care for Oklahoma's Working Families. The study concluded that it is only when families earn more than 250% of the poverty level that they begin to accumulate the disposable income required to contribute a portion of premium costs.

In a nutshell, it appears a solution to the problem of working uninsured may be unsolvable. To provide affordable health insurance to a major portion of our population which may have difficulty in making ends meet, and has to choose between essential items and health insurance, is a task which requires innovative ideas and hard

economic decisions. Until health care costs are contained, the cost shift cycle is broken, and policy decisions on how much health care the nation and Oklahoma can afford are addressed you will not see any major movement toward an equitable solution to the problem.

The Oklahoma Council on Health Care Delivery reviewed and studied many programs in other states to increase the availability of health insurance. The Council came to a consensus that the best solution would be a comprehensive approach that included revisions to the Medicaid program and incentives to increase the availability of health insurance, particularly for small employers. The Council emphasized the use of managed care delivery systems.

The Council's recommendations for increasing the availability of health insurance for the uninsured population in Oklahoma is summarized as follows:

That Oklahoma establish a program to extend health insurance coverage to employees of small and large employers. That incentives be put in place to encourage eligible small employers to provide insurance coverage to their employees in the form of tax credits, to be phased out over a five year period. That an Insurance Pool Governing Board be created to implement the small employer insurance program. The Board would be directed to determine the feasibility of implementing a program for large employers and report to the Legislature. That participation target levels be established for a five year period. If these target levels are not met by the end of

the fifth year, the State would mandate that all employers provide health insurance for their employees and dependents or pay into an Insurance Pool at a rate determined by the Insurance Pool Governing Board. If targets are met by the end of the fifth year, the provision for mandated benefits would be rescinded. The full text of the Council's recommendation is provided in the Proposed Plan to Address the Medically Uninsured in Oklahoma.

TESTIMONY OF JULI A. GREER, TULSA, OKLAHOMA

AUGUST 10, 1990 PAGE -1-

My name is Juli A. Greer. I was asked to speak today about my experience in 1988 with an HMO insurance company, Health Accord of Oklahoma.

My husband, Gordon, and I are both employed by a small family-owned business in Tulsa, Oklahoma. As the owner and all other employees had group health insurance coverage through their spouses, who were employed elsewhere, my husband and I were the only employees without group coverage. In 1987, we responded to advertisements from the Metropolitan Tulsa Chamber of Commerce and subsequently enrolled in group health insurance coverage with Health Accord of Oklahoma, Inc. Although we were required to change doctors, we were happy with our selection. Our coverage with Health Accord was effective August 1, 1987 to August 1, 1988.

In December of 1987, when our new doctor confirmed my pregnancy and agreed to deliver the child, we were very thankful for our coverage with Health Accord. The baby's due date was July 26, 1988. In compliance with company requirements, we obtained membership cards effective 8-1-87 for myself, my husband and our three children and for "Baby Greer" effective 7-1-88.

On February 4, 1988, Health Accord sent a letter notifying all subscribers of their intent to dissolve their corporation. This, of course, was a great concern for my husband and myself. As time passed we were advised by telephone that our family would be covered during our policy dates, 8-1-87 to 8-1-88. When an official of Health Accord was questioned as to what would happen if our baby was not born before August 1st, he suggested we ask our doctor to induce labor prior to the policy expiration date, since my due date was so close to policy expiration.

By letter dated March 31, 1988, Health Accord advised all members that the group care contract with Health Accord held by our employer would terminate on May 31, 1988.

On that same date, March 31, 1988, Health Accord sent letters to each doctor or "provider" stating that Health Accord's responsibility for all benefit coverage for their members would terminate on May 31, 1988, and that all referrals for treatment or services extending past May 31, 1988, would not be approved. That letter mentioned that BlueLinks would assume responsibility for some of Health Accord employer groups effective June 1, 1988. It was later learned that our group was excluded from the BlueLinks assumption.

TESTIMONY OF JULI GREER, TULSA, OKLAHOMA

Page -2-

On April 27, 1988, Health Accord sent letters to their physicians providers stating that instead of the standard 75% paid on provider claims, the Plan had decided to set reimbursement on all claims submitted for services between April 1, 1988, and until plan closing on May 31, 1988, at 27% of the fee schedule. Dr. Gray was very supportive, assuring us he would deliver the baby regardless of what fee he was paid, and expressed his extreme concern for me, as well as the baby. Due to continued stress regarding this situation, I was continually losing weight rather than gaining weight.

Because of conflicting information from different sources, we were constantly kept in a state of confusion due to the uncertainty of whether or not our child's birth would be covered. My health declined, and I was very worried about my baby's well being.

In response to a letter from PacifiCare of Oklahoma dated May 14, 1988, we applied for and were subsequently accepted for enrollment in their HMO. At that point there was still a strong indication that I would have to change doctors and hospitals, which added to my stress, since I was in the last trimester of my pregnancy.

On June 28, 1988, Health Accord sent a letter to their pregnant members setting out various qualifications for continued coverage after May 31, 1988. This included a pregnancy certification form to be completed by the physician and a "Pregnancy Enrollment" form to be completed by the patient, for return by July 8, 1988. This letter set out "Exclusions," indicating, "It covers only the member and specifically excludes all coverage for newborn...". Because of this exclusion, I gave Health Accord the information they requested, but did not sign the form agreeing to their conditions.

I then contacted the Oklahoma Health Planning Commission, who had intervened and was working with Health Accord. They were unaware of the newborn exclusion, and at their request I furnished them a copy.

Shortly afterwards I was assured by PacifiCare that no change of doctor or hospital would be required for the baby's birth and that newborn coverage would be provided.

TESTIMONY OF JULI GREER, TULSA, OKLAHOMA

Page -3-

This ordeal ended approximately two to three weeks prior to our daughter's birth on July 22, 1988. We were very happy to resolve this matter; however, it did cause a great deal of undue stress and trauma during the last trimester of my pregnancy. I know there were many others who experienced similar problems.

I wish to thank Mr. John Ellis, our agent, Ms. Sandra Downie, of the Metropolitan Tulsa Chamber of Commerce, and Ms. Jimmie Hollister, of PacificCare, who were very helpful and considerate throughout this situation.

Although we are grateful for our current family health insurance coverage, the cost is nearly \$300.00 per month, based on our age group of 18 through 39. I am extremely concerned because of the increase in premiums at 9-year intervals, with similar insurance in the 50-64 age bracket costing at least double the premiums for the 18 to 39 age bracket. In comparison to large health insurance groups, such as the U.S. Government, which charges a set fee for self-only or family coverage regardless of age, there appears to be a definite age discrimination on premiums for health insurance offered to older employees of small businesses.

Also, there seems to be another unfair difference between large groups and small groups, in that co-insurance factors appear to be much larger for small groups. My suggestion is to allow entrepreneurs and small businesses to obtain group health insurance coverage, with fees charged and services provided comparable to those of Government contracts and large companies. By utilizing the conglomerate concept, in providing affordable health insurance coverage to a large group of widely diversified companies, this should reduce the rampant abuse of welfare claims for medical assistance.

I appreciate the opportunity to present my testimony regarding our traumatic ordeal. It is hoped the issues discussed today will eventually help eliminate discrimination and provide more affordable health insurance coverage for small businesses in Oklahoma and throughout the United States.


Juli A. Greer

SUMMARY - TESTIMONY OF JULI A. GREER, TULSA, OKLAHOMA

AUGUST 10, 1990

1. JULY, 1987 - Enrolled in group coverage with Health Accord of Oklahoma HMO based on endorsement by Metropolitan Tulsa Chamber of Commerce, with family coverage policy dates of 8-1-87 to 8-1-88.
2. DECEMBER 7, 1987 - New doctor confirmed Juli's pregnancy, with due date of July 26, 1988. Membership card was obtained for "Baby Greer" effective July 1, 1988.
3. FEBRUARY 4, 1988 - Health Accord issued letter notifying subscribers of intent to dissolve their corporation.
4. MARCH 31, 1988 - Health Accord sent letters to subscribers and medical providers stating their contract would expire on 5-31-88 and no benefits would be paid after that date.
5. APRIL 27, 1988 - Health Accord sent letter to medical providers stating only 27% reimbursement, rather than the standard 75% would be paid for services rendered until plan closing date of 5-31-88.
6. MAY 14, 1988 - Letter from PacificCare HMO offered enrollment for continued coverage, which was subsequently accepted effective June 1, 1988, with indication of requirement to change doctor and hospital for baby's delivery.
7. JUNE 28, 1988 - Health Accord sent letter to pregnant members setting our qualifications for continued coverage and specifically excluding newborn coverage.
8. EARLY JULY, 1988 - Received assurance from PacificCare that no change of doctor or hospital would be required for baby's delivery and that newborn coverage would be provided. Selection of different primary care physician was subsequently required for all family members.
9. JULY 22, 1988 - Healthy baby daughter, Jamie, was born.
10. The traumatic events in the last trimester of pregnancy resulted in extreme stress to the entire family due to the uncertainty of whether or not our child's birth would be covered and if we would be required to select a different doctor or hospital prior to the baby's delivery.
11. Premiums charged and coinsurance factors on coverage for small business are discriminatory, when compared to Government and large business contracts.

FRAME LUMBER CO., INC.

128 S.W. MAIN ST. • CHECOTAH, OK 74426 • 473-2281

August 10, 1990

Mr. Chairman, distinguished panel members, I appreciate this invitation to appear on this panel and to represent other small business people faced with this serious problem.

I live in Checotah, a town of approximately 4,000 people located near Lake Eufaula. It consists of approximately 115 small businesses and two (2) small factories. The factories employ 165 persons and offer insurance benefits.

This leaves approximately 113 small businesses with a total of approximately 598 employees. Of these, only 17 businesses with 236 employers offer health care programs. This means approximately 362 will have no insurance because they can not afford it. Multiply this times the thousands of small towns across the nation and you will see the stark reality of the situation.

The majority of these small businesses are in no way able to afford the heavy burden of this insurance overhead and are struggling to maintain their businesses and make a profit. You will note that these businesses who can not afford health insurance plans employ approximately 90% of our workers in Checotah.

We are a family owned business in the third generation of operation being in the same location for 40 years. We employ an average of 12 people, five (5) of these being family members. We started a health insurance program with Blue Cross Blue Shield in the 1950's with the company paying all of the employees premiums. Business conditions were good and health care was cheaper, so we could afford to offer insurance to the employees. Then drastic changes occurred in health care cost and insurance premiums, coupled with bad economic conditions in Oklahoma. These factors forced us to change our policy on offering health care coverage.

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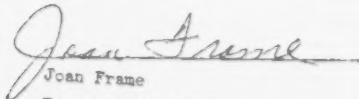
(2)

We were with Blue Cross Blue Shield for approximately 30 years, until November 1988, when they had a drastic premium rate increase. We had 11 employees on the group with a \$500.00 deductible. The only way we could have stayed with them was to go on a \$1,000.00 deductible plan, which was not feasible or affordable to the group. We shopped and compared extensively among the insurance companies available to us. In November 1988 the decision was made to go with Oklahoma Lumbermens Association insurance health program. The premium was less with more benefits and \$200.00 deductible. Total amount of premium was \$1,076.00 per month, a saving of 28% for the company, a figure we felt we could live with. Then in May 1989, 5 months after being on the program, we were notified of an increase of \$578.00 per month or 53%.

We are now facing a situation of some employees retiring soon and we are considering dropping the whole program as such because of these difficult and expensive problems. Small businesses and individuals are at such a disadvantage because they can not compete with larger companies in getting smaller premiums and have no concerted lobbying for their interest.

I sincerely hope the interested parties here, with legislative powers, will take a genuine, sincere interest and concern for the people that really are so depending on them for some help. It seems health care has become so out of proportion that the government MUST NOW step in with some kind of a working plan.

Thank you,



Joan Frame

Frame Lumber Company
128 Southwest Main Street
Checotah, Oklahoma 74426

Office
1-918-258-6866

Home
1-918-251-3359

EMPLOYER Medical-care Locators

Jerry Hunt
2316 W. Commercial Ct.
Broken Arrow, Oklahoma 74012

Group-Term-PPO-Dental
Disability Income Replacement
Annuities-Expense-Related
Subsistence-Hospital Insurance
Cancer, Life, Disability
Medicare Supplement

IRA-401(k) Conversion Policy Business Life
Executive Compensation Investments Related
Service-Contractual, General Insurance
Quote Service

August 9, 1990

101st Congress
United States House of Representatives
Committee on Small Business
Subcommittee on Antitrust, Impact of
Deregulation, and Privatization
B-363 Rayburn House Office Building
Washington, DC 20515

I believe that most Americans understand that the primary purpose of government is to serve, and protect its people. When a problem exists which cannot be solved by private enterprise, it is the government's responsibility to take charge, and solve that problem. The Medical-Meltdown has come to that point — I believe that the self-serving components of the health delivery system are out of control, and they do not have the power to stop the impending destruction — that health access has become the domain of only the "healthy and the wealthy" — that politics and special interest groups now dominate the elected representatives of the people.

I believe that the cosmetic attempts to control use of medical access has created discrimination against the working wounded — the self-employed, the individual and most businesses — with less than 100 employees. I believe the Medieval mentality of the health insurance industry underwriting practices — has created a narrow band of acceptable prospects. That rating procedures that pit the old against the young, occupation against occupation — are unjust, and unrealistic — that the right to pull out of a state a policy block of business, is nothing but white collar fraud — that dumps the uninsurable back on the streets with nowhere to go.

Recent governments attempts to create fair play in discrimination have been damaging to small employers – not to unfair insurance practices. Cobra was a wonderful idea – but if an employer wants to change carriers he must include the Cobra's in his census – the problem cases always stay on! The end result the present employees must suffer along with the company.

Most insurance carriers will not quote rates when the percent of the employees over age 50 exceed 20% – another damaging practice for the loyal workers.

The initial purpose of group insurance was a tax benefit to loyal employees – when did it all go wrong? Is it any wonder that small employers, and soon all employers will dismantle their health insurance program. So who killed the "golden goose"?

We all pay for healthcare now – even if we don't have insurance – even if we don't have a claim.

Here is how:

If you have insurance – the carriers, the providers all must make a profit – claims and inflation will increase those rates, when hospitals and Dr's treat people who can't pay, or who they must discount because of contractual arrangements they shift the loss to the payers also. When government agencies must pay for welfare, and indigent care – then taxes are used to pay – and this is shifted also to the payers. We are all ducks on the pond – the ripples hit us all.

Choices:

- A. Government takes full responsibility to coordinate and implement a National Health access program – now, and hopefully not be influenced by partition politics and lobbyist!
- B. Government expands the Medicare-Part (A) to those age 50⁺ on a voluntary basis – premiums on a earnings formula. Why is age 65 a magic #?
- C. Government gets completely out of the health insurance business – except consumer protection – and let competition have at it – See if deregulation of this business can

produce the same effects as other deregulations of recent years. The Piddling in the pond has created a lot of problems for the health business – and the public – Erisa, Cobra, Medicare Secondary, etc. (mandated benefits, IRS eliminated tax deducts – unfair discrim.-self-employed.

Lets make a list of those Americans who have access to healthcare now – employees of big companies, government – municipal employees, welfare, medicare, Indians, Veterans – I may have missed some – of course the "healthy and the wealthy" can still buy it.

It's hard to find someone to say that those people do not have a right to health care – but it is also a crime that the rest of working America doesn't have this same right. The majority of cost to furnish the health benefit to the chosen people is being paid for by the ones who can't have the insurance! Small business – self-employed!

Discrimination in America – This is wholesale discrimination

Who is guilty of this crime? – Elected representatives – special interest groups – insurance companies – health providers. It's time to do the right thing – enough is enough – not the year 2,000 – Jan. 1, 1991 – open access to healthcare for all Americans!

We can waste money in space – we can help our enemies – we can bail out investment fraud – but we refuse to take care of the people who pay the fitts. Bills.

So we didn't kill the golden goose – that would have been too merciful – we just let it die – at home – alone – and in pain...

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1-918-258-6866

Home
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EMPLOYER Medical-care Locators

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2316 W. Commercial Ct.
Broken Arrow, Oklahoma 74012

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Send David Boren
Tulsa Oklahoma
Fax # 918-581-7974
Attn: David Zesiger
office of congressman
Dennis E. Eckart - Ohio

Thank you congressman Eckart for the opportunity to share my information on the health insurance crisis for small businesses and individuals. I have been trying for years to get someone to listen to the real problems facing the public on health care access.

The leadership in healthcare look at numbers — I look at faces. I no longer can help people get insurance — My job is helping people stay insured — to keep them from losing their life, and life savings. My days are filled with frustration, and heart wrenching stories. I'm tired — I want something done! In Mark 5:9 Jesus was attempting to heal the crazy man. When Jesus asked for the name — This answer came: My Name is legion for we are many — there is too many evils in the health business nowadays.

A 63 year old woman called recently (this is only one of countless stories) she thought they had health insurance on her husband's job — But the employer couldn't keep up with the rates — the requirements, and regulations — the three rotten "R"s. So then there was none — She thought she had cancer but was afraid to go find out the truth — I encouraged her to go — create the debt — if she could — save your life — She didn't have ~~the~~ The bottom of debt

REASONS WI-

Dick Neil, a senior vice president at Principal Financial Group, was quoted in the May/June issue of *Resource* magazine: "I attribute the problems we've had in the last couple of years very largely to the rapid increase in medical costs."

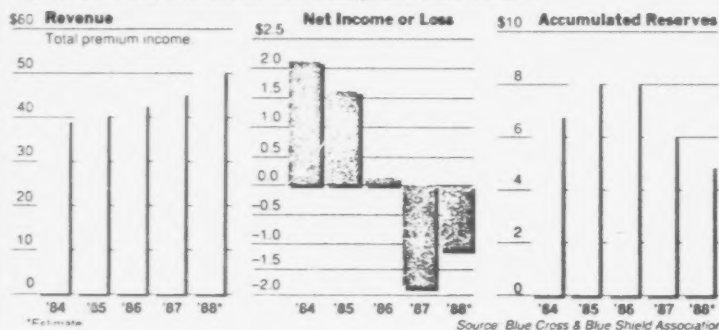
A recent *Business Insurance* article concerning a National Association of Manufacturers' (NAM) study of 2000 employers indicates that one-third of the nation's manufacturer's profits is spent on health care costs. (For the purposes of the survey, health care costs were defined as premiums employers paid to insurers for group health plans, or equivalent amounts for self-funded employers.) Obviously, the rising cost of health care is taking a big chunk out of employers' pockets.

The NAM's survey is interesting, but it doesn't tell the whole story. The fact is that costs were out-of-control in 1987 and 1988. Some opinion writers believe that 1989 may be better, but there is no solid evidence to support this.

The industry has not resolved its financial problems. The rising cost of medical care is taking its toll on both the group and the individual health insurance markets. And insurance companies who offer individual health insurance are encountering a second obstacle—regulators who deny or delay necessary rate increases because of the absence of objective approval standards. Without the ability to obtain rate increases that are proportional to the rising cost of health care, the individual major medical market will eventually disappear. (See Golden Rule's advertorial below.)

Blue Cross and Blue Shield's Financial Pressures

Figures are for all Blue Cross and Blue Shield health plans, in billions of dollars.



Competent Companies Losing Money



The National Underwriter
420 E. 4th St.
Cincinnati, Ohio
45202-9960

UNDERWRITING GAIN OR LOSS FOR TOP 12 HEALTH INSURERS (IN MILLIONS OF DOLLARS)

	1988	1987
Prudential	-83.1	-3.2
Metropolitan	+61.3	+35.7
Mutual of Omaha	-104.5	-201.0
Aetna Life	-53.0	+87.2
Conn. General	-7.7	-61.4
Travelers	-27.0	-107.2
Principal	-98.2	-11.3
Continental Assurance	+6.7	-37.9
Allstate Life	-148.5	-194.8
Provident L. & A.	-153.3	-205.9
Guardian Life	-109.4	-105.4
Lincoln National	-93.3	-92.8
TOTAL	-830.0	-898.0

& HEALTH/
ANCIAL SERVICES EDITION

NATIONAL UNDERWRITER

MAY 1, 1989

NUMBER 18 □ 93RD YEAR

Top 12 Health Insurers Lose \$830 Million In '88

BY RICHARD DONAHUE

Major health insurers, which had unprecedented underwriting losses in 1987, struggled unsuccessfully for a turnaround in 1988.

The 12 largest commercial health insurers managed to trim underwriting losses by less than 8 percent, from minus \$898 million in 1987 to minus \$830 million in 1988, according to an informal survey which was conducted by the National Underwriter.

Newark-based Prudential Ins. Co. of America, the No. 1 commercial health insurer in the nation, went deeper into health underwriting red in 1988. It lost \$93.1 million last year and \$3.2 million in 1987.

Pru's total earned health premiums climbed to nearly \$4.7 billion in 1988 from \$3.8 billion in 1987.

Aetna Life Ins. Co. of Hartford went into underwriting red in 1988, backing from an \$87.2 million gain in 1987 to a \$53 million underwriting loss in 1988.

One major health underwriter which turned around last year is Continental Assurance Co., Chicago, which had a \$6.7 million gain in 1988 and a \$37.9 million loss in 1987.

Other major insurers which went deeper in underwriting red on health lines last year are Principal Mutual Life Ins. Co., Des Moines, which went from minus \$11.3 million in 1987 to minus \$98.2 million in 1988, and Guardian Life Ins. Co.,

New York City, which had an underwriting loss of \$105.4 million in 1987 and \$109.4 million in 1988.

Companies which trimmed losses included Provident Life & Accident, Chattanooga, from minus \$205.9 million in 1987 to minus \$153.3 million in 1988; Travelers Ins. Co., Hartford, from minus \$107.2 million to minus \$27 million; Allstate Life, Northbrook, Ill., from minus \$194.8 million to minus \$148.5 million, and Connecticut General Life Ins. Co., Bloomfield, Conn., from minus \$61.4 million to minus \$7.7 million.

Unprecedented Losses Of '87 Trimmed By 8%

Mutual of Omaha, the third largest commercial health insurer in the country, pared its health underwriting losses from \$201 million in 1987 to less than \$104.5 million in 1988.

Lincoln National Life, Fort Wayne, Ind., experienced health insurance underwriting losses of about \$93 million in both 1987 and 1988.

The turnaround struggle continued in 1989.

"We think the underwriting cycle for health insurance is turning upward," said Mike Sebold, marketing vice president for Illinois Blue Cross and Blue Shield, Chicago.

The Illinois Blues lost \$32.1 million in 1987, cut its losses to \$3.3 million in 1988, and expects to make a profit in 1989, Mr. Sebold said.

Blue Cross—Blue Shield of Illinois provides health insurance for over two million persons in the state. In 1988 it took in \$1.65 billion in premium, making it the seventh largest health insurer in the country if ranked with commercial insurers.

New York City-based Metropolitan Life Ins. Co.—which took in nearly \$2.4 billion in health premiums last year and is the second largest commercial health insurer in the country—had an underwriting gain of more than \$51 million in 1988 and over \$45 million in 1987 on premiums of \$1.9 billion.

Met attributes part of its relative success in the volatile A&H lines to the aggressive use of managed care in its group plans.

"I think companies will find that unless they are operating in a managed health care environment they will have great difficulty in controlling medical care costs," said Philip Briggs, vice chairman of Metropolitan and newly elected chairman of Health Insurance Association of America.

Managed care, Mr. Briggs said, means negotiating fees with doctors, negotiating rates with hospitals, and eliminating waste—such as unnecessary procedures—in the health care delivery system. □

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Children's Medical Center



GERARD J. ROTHLEIN, JR.
President and Chief Executive Officer

STATEMENT BY
GERARD J. ROTHLEIN, JR.
PRESIDENT AND CHIEF EXECUTIVE OFFICER
OF
CHILDREN'S MEDICAL CENTER
BEFORE
U.S. HOUSE SMALL BUSINESS SUBCOMMITTEE
ON ANTITRUST, IMPACT OF
DEREGULATION AND PRIVATIZATION
AUGUST 10, 1990

P.O. Box 35648 5300 East Skelly Drive Tulsa, Oklahoma 74153 918 664-6600

Good afternoon, Mr. Chairman and distinguished committee members. My name is Gerard J. Rothlein, Jr. I am past Executive Vice President of First National Bank and Trust, and currently the President and CEO of Children's Medical Center. I am also past Chairman of the Tulsa Program for Affordable Health Care, past Chairman of the Metropolitan Tulsa Chamber of Commerce Health Care Delivery Task Force, current Treasurer of the Tulsa Community Foundation for Indigent Health Care, and Governor's Appointee to the Oklahoma Council on Health Care Delivery. It is in through these positions that I have had the opportunity to familiarize myself with a variety of health-care related issues and be a part of the process of designing and implementing solutions to the very real problems.

Oklahomans are certainly not alone as far as the type and variety of health care concerns with which we must deal. Many of the problems which we face are the same as those faced by citizens in other states throughout the nation. Generally, these fall into two broad categories: 1) How do we provide the broadest possible access to the best possible quality of health care; and 2) How do we do so at the most affordable price? We have the same populations who are not receiving adequate health care as do other states. These are the employed/uninsured and the indigent. In addition, we have many citizens who believe that they have adequate health insurance coverage but who are, in reality, either somewhat or substantially underinsured. The fact that so many people have inadequate coverage means, by definition, that many of them are going to receive inadequate health care. Also, the effect of placing virtually the entire cost of maintaining the health care system on those individuals and businesses maintaining adequate health insurance coverage means that this latter group is, through a grossly disproportionate allocation of costs,

subsidizing health care for all citizens.

The Metropolitan Tulsa Chamber of Commerce recognized this problem and attempted to address it, in part, through its administration of a grant from the Robert Wood Johnson Foundation. This grant allowed us to develop the Tulsa Health Option, which significantly expanded the number of citizens in this community covered by health insurance. Through this program and through other marketing approaches which have helped develop and administer, we provide benefits to many individuals and, at the same time, spread the cost over a broader base. We also supported the enactment by the Oklahoma Legislature of SB 346. This legislation creates a mechanism for providing health insurance to many more employed/uninsured Oklahomans and establishes incentives for their employers to participate.

The Tulsa Chamber has also considered what can be done for our indigent population. Existing funds are insufficient and they are distributed inequitably throughout the state. Furthermore, the dollars are often not spent in the most productive ways. We believe that redirecting more existing funds into prenatal and perinatal care can greatly increase the benefits derived from available monies. Also, we believe that it is worth investigating whether or not public monies can be better spent through private insurance and health organizations. It may well be that significant efficiencies are attainable by reducing the cost of administering health care funds with more money going directly into the providing of services. We are actively participating in the development of pilot projects to evaluate these approaches.

But even if all Oklahomans (and all Americans) have adequate

insurance coverage, we have not solved the health care crisis. We must satisfy ourselves that intelligent decisions are made as to what type of services can and should be provided in the best interests of both individual patients and the population as a whole. We believe that managed health care can make a difference in this area. We have seen the beginnings of progress as health maintenance organizations (HMO's) have begun to play a larger role in the marketplace in Oklahoma. These organizations not only act to insure that health costs are paid for, they also attempt to curtail costs without undermining the quality of care provided. They continue an initiative begun by the medical community itself -- technology assessment. Such technology includes medication, medical equipment and medical and surgical procedures used in health care and the organization and support systems that provide such care. Technology assessment is a form of policy research. It examines both the short- and long-term consequences of the application of technology. These consequences include clinical, societal, economic, ethical and legal issues. As a state and as a nation, we must encourage this process. We must continually look at the effectiveness, safety and cost of medical technology for each clinical application. While the medical community is to be applauded for its efforts in this area, those of us in business, government and the population as a whole must realize that there should be something other than an academic approach to this process. We cannot reasonably expect a laboratory which has invested heavily in a machine to reassess its use before it is fully paid for.

The issues relating to providing good quality and cost-effective health care in this country are complex. There are no simple answers. Certainly, government has an important role to play. But the medical

community and all other segments of our state and our nation must participate in the process. We hope to be a productive player.

I appreciate having the opportunity to appear before this panel.
Thank you.

TESTIMONY OF
BLUE CROSS AND BLUE SHIELD OF OKLAHOMA

HEALTH INSURANCE IN THE
SMALL GROUP MARKET

BEFORE THE
SUBCOMMITTEE ON ANTITRUST,
IMPACT OF DEREGULATION AND PRIVATIZATION
COMMITTEE ON SMALL BUSINESS

AUGUST 10, 1990

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA

EXECUTIVE SUMMARY

There are many components that affect the cost of health care -- practice patterns of providers, consumer demand, legislative and regulatory actions, new technology, demographic changes, and costs associated with medical malpractice, to name a few. These must be scrutinized to address the small business health insurance situation.

Blue Cross and Blue Shield of Oklahoma has developed an agenda, as follows:

1. Provide leadership in local communities regarding uncompensated health care. We have been an active participant on nearly every major task force or committee that is researching the problems of this state's uninsured.
2. Aggressive product development to address the needs of the uninsured. For example, Basic, a Safety Net Plan, which is specifically designed for the "working uninsured" was introduced earlier this year.
3. Review health care provider payment arrangements. We have health care provider networks contracting with as many as 3,350 physicians, 120 hospitals, and 900 pharmacies. Physician special payment arrangements for our subscribers range from 7-18% less than billed charges and hospital payment arrangements range from 12-24% less than billed charges.

We support the following changes to further address the problem of the uninsured:

1. Amend ERISA to preempt state laws that require all insurance products to include costly health benefits.
2. Offer tax credits and subsidies to small employers who provide employee health care coverage.
3. Allow self employed individuals to deduct 100% of their premiums.
4. Revise the Medicaid program to expand eligibility to persons at or below the federal poverty level.
5. Explore a state risk pool for the uninsurable and require self-funded companies to share in the financing of state risk pool losses.

August 10, 1990

Mr. Chairman, and Members of the Committee, I am Ronald F. King, Senior Vice President of Blue Cross and Blue Shield of Oklahoma. I appreciate being included on this panel and having the opportunity to talk to you about small business health insurance.

Because Oklahoma ranks eighth in the nation in the number of uninsured, much attention has been focused on this problem in the state. And because more than three-fourths of the uninsured are workers and their dependents, this focus has turned to the problems faced by employees of small businesses which do not provide health care benefits.

This group of employees and dependents may be able to meet most other basic living expenses, but simply cannot afford health insurance. They take their chances against illness and injury. And they often lose the gamble.

Specific concerns about the small group health insurance market include the cost of coverage and the availability of reasonably-priced insurance products for groups that have high-risk, high-cost employees.

So, when we talk about the "uninsured" or when we talk about the problems of small business health insurance, we're really talking about many of the same people.

Before we discuss the programs being implemented by Blue Cross and Blue Shield of Oklahoma to extend private insurance coverage to more of the uninsured population, I believe it is important to understand how we got to where we are today. First, I will comment on the issue of affordability. Second, I will discuss how the small group health insurance market has evolved over time.

In addressing the larger issue of why many small employers find health insurance unaffordable, it is important to understand that there are many components of health care cost increases. These include practice patterns of providers, consumer demand for health care services, new technology, demographics changes and costs associated with medical malpractice, to name a few.

Each of these components, and more, affect the cost of health care. And they affect the cost of health insurance.

Blue Cross and Blue Shield of Oklahoma has a long history of accomplishments in helping to control costs. We've worked with doctors, hospitals and subscriber groups and together we've developed aggressive programs to help control unnecessary utilization.

We have signed agreements with hospitals and physicians that limit our subscribers' liability and assure that we pay only a reasonable amount for covered services.

Our cost control efforts also include case management, managed care, and utilization and medical necessity review.

However, it is important to understand that even with the most aggressive cost containment efforts, the cost of health care benefits will remain a problem for many employers. This is particularly true for small, marginally profitable employers.

In addition to these overall cost problems, small employers face additional costs from legislative and regulatory actions. In particular, state mandated benefit and provider laws add to the cost of coverage for small groups.

Large employers, through ERISA, can avoid the cost of these mandates by self-insuring, but small employers do not have this option because they cannot bear the risk of large claims. Large claims such as premature infants, organ transplants, heart bypass surgery, etc. can easily exceed hundreds of thousands of dollars. The increase in the number of these large claims has added substantially to the cost of health care benefits. Pre-empting these state mandate laws, at least for small employers, through the federal Employee Income Security Act (ERISA), would allow insurers to develop lower-cost benefit packages that would be more affordable to small employers.

Oklahoma recently enacted legislation to establish special low-cost health insurance coverage for uninsured small employers. Other states, including Virginia, Washington, Kentucky and Rhode Island have enacted similar legislation. The Oklahoma law also establishes tax credits for employers who purchase coverage for their employees.

Other factors also contribute to higher insurance costs for small employers. In particular, small groups expose insurers to greater risk of "adverse selection" -- that is, the risk that a group will be a worse than average risk. Other factors include a smaller base of employees and premiums over which to spread expenses and high turnover of small group policies, which leads to both higher claims costs and higher administrative costs.

Notwithstanding these cost issues, however, we recognize that certain insurer practices have an effect on both the cost and availability of coverage for small employers. However, these practices have evolved over time, in response to the demands of the marketplace.

When Blue Cross and Blue Shield of Oklahoma first began providing health insurance coverage in 1940 every applicant was accepted for coverage, regardless of health status or age.

Then competitors entered into the health insurance market and started using underwriting practices like those we're familiar with. Things like age rating, charging higher rates to higher risk applicants, denying coverage for pre-existing health conditions and denying coverage for high-risk applicants.

You can imagine what happened. The insurers who screened their applicants and accepted only lower-risk people were able to have more competitive prices. Their enrollees used their benefits less, so the insurers paid less in claims, and were able to charge lower premiums.

The insurers with more liberal enrollment practices lost their low-risk enrollees to this better-priced coverage. They were left with higher-risk enrollees who had nowhere else to go.

This process is known as the "adverse selection spiral" and explains why few insurers can accept high-risk groups and stay competitive.

These selection problems are particularly acute in the small group market. Small employers, who typically have marginal profitability, are extremely price sensitive and are more willing than large employers to switch insurers to get a lower price. This price sensitivity has increased in the last 5-6 years as health care costs have escalated.

This gives you an idea of how we got to where we are. Now, what to do about it.

Earlier this year, the national Blue Cross and Blue Shield Association issued a policy statement regarding health benefits for the uninsured. An agenda for change includes: increasing insurance coverage of low and moderate income individuals and families by offering innovative programs; assuring the availability of private coverage to all small employers at a fair price; reviewing health care provider payment arrangements to assure effective use of subscriber premiums; and promoting federal legislative reforms that encourage the purchase of insurance and improve national and state programs for low-income individuals.

In Oklahoma, Blue Cross and Blue Shield has addressed each of these issues and is aggressively working to reduce the number of Oklahomans without health insurance protection.

Our company has been an active participant on nearly every major task force or committee that is researching the problems of this state's uninsured. This includes the Oklahoma City Chamber of Commerce, the Tulsa Chamber of Commerce, the Oklahoma State Chamber of Commerce and Industry, the Oklahoma Council on Health Care Delivery, the Tulsa Program for Affordable Health Care and special task forces appointed by the legislature. We also have

worked with the Governor and his staff in addressing the problem of the uninsured.

In fact, in January of this year Governor Bellmon joined us in introducing a new health insurance plan designed specifically for the working uninsured. The program is called Basic, a Safety Net Plan, and it's available statewide to individuals and families who are self-employed, employed by small companies, and part-time employees.

We started pursuing a low-cost benefits plan when our marketing staff began reporting that many employers were citing cost concerns as their primary reason for not providing health insurance plans for their employees. The research that followed led to the development of our new Basic product with a target price of less than \$50 for individuals. We worked with businesses throughout the state, the Governor and his staff, legislators, hospitals, and physicians to design a plan that answered the request for lower premium rates and basic health care protection.

Basic offers benefits for inpatient and outpatient hospital care, hospital maternity and nursery services and physician services for surgery, inpatient doctor care, maternity and obstetrical care. Family coverage also includes special benefits for prenatal physician visits, well-baby care during the first year, and childhood immunizations until age eight.

Basic is available to both individuals and small business groups, is age rated and is medically underwritten. Our rate for an individual age 35-39 is \$48 per month.

We also support the national Blue Cross and Blue Shield policy that the insurance industry must find a way to make private coverage available to all small employers at a fair price. However, because not all insurers can bear the risk of accepting high-risk applicants, some way of fairly distributing the costs of these high risk enrollees must be found. Our Association currently is working on developing options to achieve this objective.

We believe that these changes will help move the small group insurance market from one where competition is based on risk selection to one where competition is based on administrative efficiency, services and ability to control costs.

The third part of our policy suggests that health care provider payment arrangements be reviewed to assure effective use of subscriber premiums. This is an area in which Blue Cross and Blue Shield of Oklahoma has never been stronger.

We have signed agreements with hospitals, physicians and other providers resulting in statewide networks. These networks allow us to negotiate special payment arrangements for our subscribers and, in return, we pay the providers directly for their services. This can increase the providers' patient load and decrease their collections.

Right now we have three statewide provider networks. Directories are published for our subscribers' use.

Our core network is called PAR-NET. It includes 3,350 physicians, 120 hospitals, and more than 900 pharmacies. We currently have more than a quarter million subscribers who can take advantage of the PAR-NET network.

Our PPO network was expanded in 1988 to include small businesses. The PPO network includes nearly 2,300 physicians, 35 hospitals and 130 pharmacies. We have more than 160,000 subscribers enrolled in our PPO programs.

Special payment arrangements in our provider networks range from 7-18% less than billed charges for physician services and from 12-24% less than billed charges for hospital services. These networks have definitely given our subscriber "significantly more bang for their buck."

Providers accept our maximum reimbursement allowance as payment in full, plus applicable deductibles and copayments. Our subscribers have saved literally millions of dollars in out-of-pocket expense over the past few years.

From the things I've mentioned, you can see that Blue Cross and Blue Shield of Oklahoma is actively looking for ways to reduce the number of uninsured Oklahomans. However, we would stress that when considering ways to bring about desired changes, it is important to remember that the current system did not develop overnight but rather evolved over several years time in response to very real market pressures. Thus, any changes in the current system must include a transition period in order to assure continued stability in the marketplace.

Obviously it's going to take a continued effort and a creative approach to begin to solve these problems. It's also going to take government, business, doctors, hospitals, and insurers working together.

The final areas of change that we are supporting are legislative reforms to encourage the purchase of insurance coverage and improve coverage of low-income individuals and families. Specifically, we recommend:

1. Amending ERISA to preempt state laws that require costly health benefits be included in all insurance products. These mandates can add as much as 20% to the premium and can keep insurance from designing the most cost effective benefits packages for small employers.
2. We also believe that the federal tax code should be revised to create incentives for small business to provide employees with health insurance, for example, through tax credits or subsidies.
3. In addition, self-employed individuals should be allowed to deduct 100% of their premiums.
4. We support changes to the Medicaid program to expand eligibility to persons at or below the federal poverty level.
5. We also think the state should explore establishing a high-risk pool for uninsurable individuals. And in order to assure equity in the financing of pool losses, ERISA should be changed so that self-funded companies would be required to share in the financing of risk pool losses.

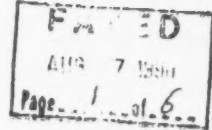
In closing, we believe that the private and public sectors must work together to improve access to care for the uninsured. We will continue to pursue enhancing private sector coverage, and believe that we can help solve this problem if we have governmental support to offer more affordable packages and tax incentives for certain employers to offer benefits. To address the coverage problems of the low-income, we recommend improvements to the Medicaid program. Finally, we believe that we must work together to address the underlying problem of escalating health care costs.

Thank you for the opportunity to present our views today.

PHONE 918/587-9114
FAX 918/587-9110



P.O. 1
MAILING ADDRESS
P.O. BOX 52429
ZIP CODE 74152
PLANT ADDRESS
1118 NORTH PEORIA
ZIP CODE 74106



MEMORANDUM

DATE: 8/7/90

TO: Mr. David Zesiger fax 202/225-1035

FROM: Ted Bynum

RE: Subcommittee on Antitrust, Impact of
Deregulation and Privatisation

My testimony to be given 10/10/90 will follow the outline below:

- I. Welcome and appreciation for interest;
- II. Company background and profile;
- III. Company cost history for medical coverage (see Exhibit III-A);
- IV. N.F.I.B. efforts at cost containment/coverage availability;
- V. Personal plea for 'phase-in' coverage enabling insureds to switch to lower cost plans without sacrificing coverages;
- VI. Close.

Please find attached Exhibit III-A, a synopsis of my background and current interests and the lead pages from our product literature.

Let me know if you have any suggestions, comments or advice.

SERVING INDUSTRY SINCE 1932

Exhibit III-A Ted Bynum testimony 10/10/90

G. T. BYNUM CO. FAMILY COVERAGE BLUE CROSS/BLUE SHIELD OF OKLAHOMA

Group No. 01386C00 B.S. Plan Code 840 B.C. Plan Code 340

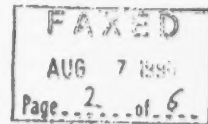
Type Coverage: Healthshare BC OED 12-1-46

COVERAGE:	Effective:	Deduct:	Co-Ins:	
Hospital	4/1/83	\$500		family
Medical	4/1/83	\$200	20%	family
Supp Acc Cov 300	4/1/83			family

All contracts include OB

YEAR	COST/YEAR	INCREASE FROM PRIOR YEAR	2 YEAR AVERAGE INCREASE	3 YEAR AVERAGE INCREASE
1990	\$4,764.60	36.96%	20.17%	8.88%
1989	\$3,478.80	3.39%	-5.17%	10.00%
1988	\$3,364.80	-13.72%	13.31%	9.01%
1987	\$3,900.00	40.34%	20.38%	17.28%
1986	\$2,779.00	0.43%	5.75%	
1985	\$2,767.20	11.08%		
1984	\$2,491.20			

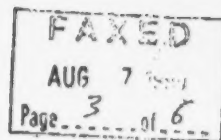
source: Barbara Evans, Secy to Mr. Bynum



07-Aug-90 DATE printout

G. TED BYNUM III

P.O. Box 52429
TULSA, OK 74152
918/587-9118

**PROFESSIONAL:**

67-PR President (78-PR), G. T. BYNUM CO., Tulsa manufacturing firm founded in 1932 producing and servicing pipe cleaning and straightening machines, prestressed concrete tensioning equipment and hydraulic presses, cylinders and equipment;

75-PR President, TEDCO INC., Tulsa holding company with interests in leasing, specialty manufacturing and security sales;

81-PR President, GLS CORP., Tulsa oil and gas production and exploration firm;

86-PR Management/Personnel Consultant to small business.

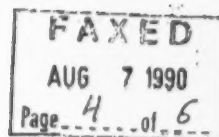
CIVIC / PROFESSIONAL AFFILIATIONS:

- * Member, American Red Cross/Tulsa Area Chapter (ARC/TAC) Executive Committee;
- * Member, ARC/TAC Board of Directors;
- * Chairman, ARC/TAC Strategic Planning Committee;
- * Chairman, ARC/TAC Tissue Services Committee;
- * Member, ARC/TAC Budget, Shared Services and Public Relations Committees;
- * Advisory Director, Tulsa Area United Way;
- * Chairman, National Federation of Independent Business Oklahoma Advisory Council;
- * Vice-Chairman, Metropolitan Tulsa Chamber of Commerce (MTCC) Small Business Council (SBC) Steering Committee;
- * Chairman, MTCC SBC Awards Nomination Committee;
- * Member, Governor's Conference on Small Business Steering Committee;
- * Delegate, 1986 White House Conference on Small Business;
- * Member, Tulsa World Trade Foundation;
- * Member, Tulsa County Historical Society (TCHS) Board of Directors;
- * Chairman, TCHS Nominating Committee;
- * Member, Philbrook Art Center;
- * Member, Tulsa Zoo Development Inc.;
- * Member, Cascia Hall Alumni Association;
- * Member, Cascia Hall Parents and Faculty Association;
- * Member, Monte Cassino Parents and Teachers Association;
- * Volunteer Teacher, Peary Elementary School;
- * Coach, Central Tulsa Starlets Girls Soccer Team;
- * Coach, Monte Cassino Stars Girls Softball Team;
- * Blood Donor Coordinator, Eastern Oklahoma MENSA;
- * Member, INTERTEL;
- * Life Member, Sigma Chi Fraternity.

G. TED BYNUM III

P.O. Box 52429
TULSA, OK 74152
918/587-9118

CONTINUED

**EDUCATION:**

1973 Bachelor of Science in Business Administration
(Management and Finance), The University of Tulsa College
of Business.

CERTIFICATIONS:

1982 Emergency Medical Technician, St. John Medical
Center, Tulsa, OK, National Registry NA-540252;

1986 Open Water Scuba Diver, P.A.D.I..

PERSONAL:

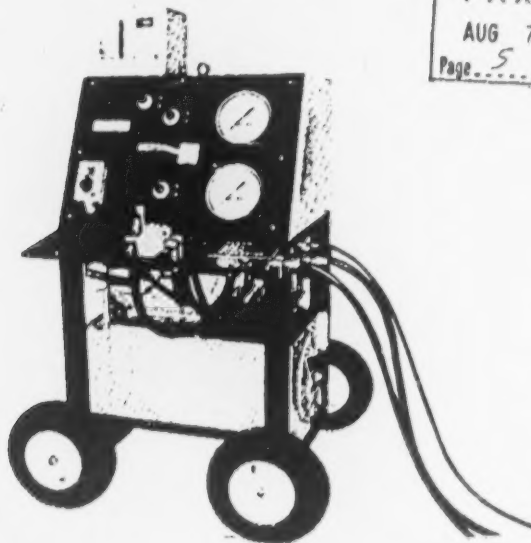
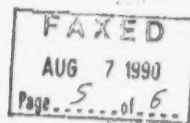
Born January 14, 1951, Camp Polk, LA;

Married to Suzanne LaFortune Bynum August 7, 1971;

Children: G. T. IV; Lindsey Suzanne; Margaret Mallory;
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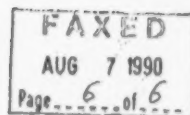
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(DRAFT)

Gerry Hillen
628-6322

Good morning! My name is Lebnard J. Eaton, Jr. I am Chairman and CEO of the Bank of Oklahoma and Chairman-elect of the Board of Directors of the Metropolitan Tulsa Chamber of Commerce. I am also the immediate past chairman of the Community Development Division of the Tulsa Chamber. It is in that capacity that I have had the opportunity to familiarize myself with a variety of health-care related issues and be a part of the process of designing and implementing solutions to the very real problems.

Oklahomans are certainly not alone as far as the type and variety of health care concerns with which we must deal. Many of the problems which we face are the same as those faced by citizens in other states throughout the nation. Generally these fall into two broad categories: 1) How do we provide the broadest possible access to the best possible quality of health care?; and 2) How do we do so at the most affordable price? We have the same populations who are not receiving adequate health care as do other states. These are the employed/uninsured and the indigent. In addition, we have many citizens who believe that they have adequate health insurance coverage but who are in reality either somewhat or substantially underinsured. The fact that so many people have inadequate coverage means, by definition, that many of them are going to receive inadequate health care. Also, the effect of placing virtually the entire cost of maintaining the health care system on those individuals and businesses maintaining adequate health insurance coverage means that this latter group is, through a grossly

disproportionate allocation of costs, subsidizing health care for all citizens.

The Metropolitan Tulsa Chamber of Commerce recognized this problem and attempted to address it in part through its administration of a grant from the Robert Wood Johnson Foundation. This grant allowed us to develop the Tulsa Health Option which significantly expanded the number of citizens in this community covered by health insurance. Through this program and through other marketing approaches which we have helped develop and administer we provide benefits to many individuals and at the same time spread the cost over a broader base. We also supported the enactment by the Oklahoma Legislature of SB 346. This legislation creates a mechanism for providing health insurance to many more employed/uninsured Oklahomans and establishes incentives for their employers to participate.

The Tulsa Chamber has also considered what can be done for our indigent population. Existing funds are insufficient and they are distributed inequitably throughout the state. Furthermore, the dollars are often not spent in the most productive ways. We believe that redirecting more existing funds into prenatal and perinatal care can greatly increase the benefits derived from available monies. Also, we believe that it is worth investigating whether or not public monies can be better spent through private insurance and health organizations. It may well be that significant efficiencies are attainable by reducing the cost of administering health care funds with more

money going directly into the providing of services. We are actively participating in the development of pilot projects to evaluate these approaches.

But even if all Oklahomans (and all Americans) have adequate insurance coverage we have not solved the health care crisis. We must satisfy ourselves that intelligent decisions are made as to what type of services can and should be provided in the best interests of both individual patients and the population as a whole. We believe that managed health care can make a difference in this area. We have seen the beginnings of progress as health maintenance organizations (HMO's) have begun to play a larger role in the marketplace in Oklahoma. These organizations not only act to insure that health costs are paid for, they also attempt to curtail costs without undermining the quality of care provided. They continue an initiative begun by the medical community itself --technology assessment. Such technology includes medication, medical equipment and medical and surgical procedures used in health care and the organization and support systems that provide such care. Technology assessment is a form of policy research. It examines both the short- and long-term consequences of the application of technology. These consequences include clinical, societal, economic, ethical and legal issues. As a state and as a nation we must encourage this process. We must continually look at the effectiveness, safety and cost of medical technology for each clinical application. While the medical community is to be applauded for its efforts in this area those of us in business,

government and the population as a whole must realize that there should be something other than an academic approach to this process. We cannot reasonably expect a laboratory which has invested heavily in a machine to reassess its use before it is fully paid for.

The issues relating to providing good quality and cost-effective health care in this country are complex. There are no simple answers. Certainly, government has an important role to play. But the medical community, the business community and all other segments of our state and our nation must participate in the process. We hope to continue to be a productive player.

I appreciate having the opportunity to appear before this panel. Thank you.



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VOLUME 67, NO. 33 June 28, 1990

Tulsa Health Option

Plan Compares Favorably

Over the past decade, the Chamber has undertaken many initiatives to improve access to health care coverage for small businesses.

The most significant of these efforts, the Tulsa Health Option - a comprehensive medical care package - has been marketed to both small and large employers for nearly four years. Designed to encourage cost effective, high-quality care, the Tulsa Health Option provides affordable coverage to Tulsa area firms.

The Community Development Division wanted to find out how the program's premiums compare with rates in other cities that target small companies. The Division compared the Tulsa Health Option to one of the most successful programs in the country which is sponsored by Cleveland's Council of Small Enterprises, the largest local small business organization in the country.

The program is sponsored by a division of the Cleveland chamber, the Greater Cleveland Growth Association.

The program has heavily penetrated the Cleveland marketplace with its health plans.

The Tulsa Health Option compares favorably with the Cleveland plans. For example, HMO monthly premiums averaged \$97 for single coverage under the Cleveland program, compared to \$89 for the Tulsa Health Option. Family coverage under the Cleveland program

averaged \$261 per month, compared with \$253 under the Tulsa Health Option.

The Division also compared the Cleveland program's indemnity plan rates with those of the Tulsa Business Health Group - Cleveland pools many small groups into one large group to secure rates comparable to those paid by large businesses. Large firms belonging to the Tulsa Business Health Group offer the Tulsa Health Option plan to their employees.

The Cleveland plan closest to the typical offering by the Tulsa Business Health Group was used to compare

Continued on Page 2

C-C Opposes S.T.O.P. Taxes

The Chamber opposes two initiative petitions which call for the repeal of House Bill 1017 and require a vote of the people on any tax increases.

The Chamber's Board of Directors voted unanimously to oppose initiative petitions 347 and 348 filed by a group called S.T.O.P. New Taxes.

Initiative Petition 347 (State Question 639) would repeal all new language encompassed in House Bill 1017 and would return the laws regulating education and taxes to

read as they did before the legislation was passed.

The Chamber strongly supported the education reform/tax bill and therefore opposes any effort to undo the great strides it makes toward improving Oklahoma's educational system.

The second initiative petition, 348 (State Question 640), would require any bill passed by the Legislature to raise revenue for state government to be submitted to a vote of the people.

The Board of the Metropolitan Tulsa Chamber of Commerce opposes the petition believing that, if passed, it would bring about poor public policy, in that the Legislature would be abdicating its role in a "town hall" process.

It also could discourage the Legislature from reducing taxes because it might fear that at some point in the future it would be impossible to re-establish taxes at their prior level.

BUSINESS AFTER HOURS

July 26

**LOOKS
Furniture
Leasing**

Health

Continued from Page 1

monthly premium rates (although Cleveland offers its members a wide variety of indemnity plans).

The Cleveland plan averaged \$187 per month for single coverage, compared with \$101 a month for the Tulsa Business Health Group. Family coverage average \$435 under the Cleveland plan, compared with \$279 for the Tulsa plan.

For more information, contact Sandra Downie, Vice President of Community Development.

FAM Tours Help Sell City

Executives from across the country were in Tulsa this month for the Convention & Visitors Division's latest familiarization tour.

"Seeing is believing" is the theory behind the FAM tours which showcase the area and help dispel myths about Oklahoma.

Twenty association executives and guests from across the country attended the FAM tour June 21-23. The tour focused on Oklahoma's western heritage and included visits to Discoveryland, Gilcrease, Allen Ranch and Will Rogers Museum.

The first of three FAM tours planned for 1990 was May 17-19.

It highlighted Mayfest activities as well as meeting facilities and services available in Tulsa.

Thirty three association executives and guests toured Mayfest, the Convention Center, hotel properties and they went on a tour of Tulsa during their brief stay.

One association which was represented at the May FAM tour already has confirmed it will be holding a meeting in Tulsa.

The Convention & Visitors Division reports about 30 percent of the associations which attend a FAM tour will book a meeting in Tulsa as a result.

The third FAM is planned for September 6-8 and it will highlight the Chili Cookoff/Bluegrass Festival.

The FAM tour has become one of the most successful marketing tools for the city.

The tours are made possible by in-kind contributions from many segments of the hospitality community. Contributions include airline tickets, lodging, meals, tours and ground transportation.

NOEDA Sets Annual Meeting

Leaders will share information, ideas and plans for Oklahoma's future at the 1990 annual meeting of the Northeast Oklahoma Economic Development Association.

Key community leaders from the public and private sector will participate in the meeting July 12 & 13 at Shangri-La Resort. Registration is \$50.

Contact Shangri-La directly for room reservations at 1-800-722-4903.

Discussions will include Industrial Real Estate and Development; Tourism; Marketing and Product Development; Bond Financing in Oklahoma; and Certified Cities.

For more information contact Linda Hensley, NOEDA.

DOC To Open Calif. Office

In a move to launch a more aggressive business recruitment effort on the West Coast, the Oklahoma Department of Commerce has announced it will establish a state office in Southern California effective July 1.

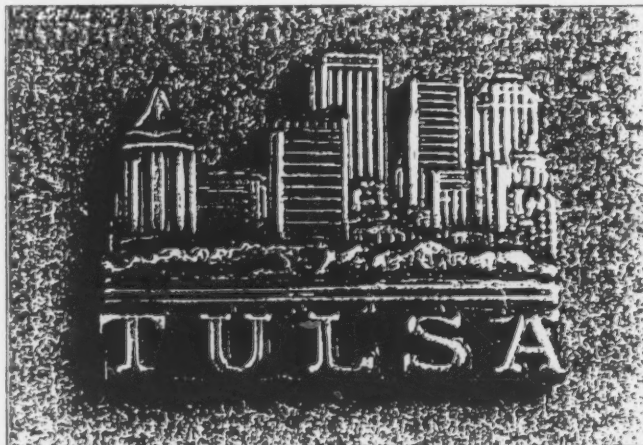
Commerce Secretary Don Paulsen said plans call for the office to be located just south of Los Angeles in the rapidly developing Orange County area. The office will be staffed by Jay H. Allbaugh, former director of the Edmond Industrial Authority.

Establishment of the office is the direct result of joint recommendations by Oklahoma Futures, legislative leaders and various economic development organizations across the state.

The Oklahoma Legislature provided funding of \$175,000 for the office in the Commerce Department's fiscal year 1991 budget.

The primary role of the Oklahoma office will be to investigate, identify and recruit California businesses looking for alternative operating sites.

A formal office opening is planned for early September.



SHOW PRIDE WITH TULSA PINS

Tulsans can show their pride with a new skyline TULSA pin. The gold overlay lapel pins are available from the Economic Development Division. They will be presented by the Mayor to visiting dignitaries and available to the public for \$10 apiece while supplies last. Contact the Economic Development Division.

TULSA.

Metropolitan Tulsa Chamber of Commerce

ROUTE TO:

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VOLUME 67, NO. 32 June 21, 1990

Health Group Completes Survey

The Tulsa Business Health Group recently completed its annual membership survey of health plans which compares prices and enrollments.

The Health Group, which includes Tulsa's largest employers, was formed in the early 1980s to study ways to make company benefit plans more efficient and to ease the financial burden caused by the area's medically uninsured population.

The survey is a year-to-year comparison of company health plan prices and enrollments in both indemnity plans and alternative health plans, including HMOs and PPOs.

Survey findings:

HMO Enrollments Stable

Company enrollments in HMOs were stable from 1989 to 1990, although there has been a dramatic shift since 1988 in enrollment among local HMOs.

One HMO experienced substantial enrollment gains over the last two years. Penetration by non-traditional health care plans remained high among Tulsa Business Health Group members, with about 40 percent of their employees enrolled in alternative health plans.

Several companies reported more than half of their employees were enrolled in these health plans. National HMO penetration is 13 percent of the population; statewide HMO penetration is 5 percent, according to the Marion Managed Care Digest/HMO Edition 1989.

Indemnity Premiums Up

Companies in general experienced significantly higher rate increases over the last year in their indemnity plans than in their HMO plans.

This finding was especially apparent in the single employee coverage, although price increases varied substantially from company to company. For example, one employer experienced a 68 percent increase, compared with an 8 percent increase for another Health Group member for employee-only coverage.

Overall, HMO premium increases averaged 13 percent for

Continued on Page 2

Cole Appointed To OK Futures

The President of the Metropolitan Tulsa Chamber of Commerce, Clyde C. Cole, has been reappointed as a member of Oklahoma Futures by Senate President Pro Tempore Robert V. Cullison. Cole's reappointment is for a four-year period ending June 30, 1994. Cole originally was appointed in 1987 by then Senate President Rodger Randle.

Oklahoma Futures, created by the Legislature in 1987, serves as the

principal economic development policy planning and oversight board for the state's economic development efforts, with particular emphasis on the programs and activities of the Department of Commerce.

The Board of Oklahoma Futures is comprised of the Governor, Lieutenant Governor, Senate President Pro Tempore, Speaker of the House of Representatives, Chairs of the Senate and House Economic Development Committees, Executive Director of the Department of Commerce, Chairman of the State Chamber of Commerce, President of the AFL-CIO, and Presidents of the University of Oklahoma and Oklahoma State University, as well as representatives from the Oklahoma Cattlemen's Association and Wheat Growers' Association.

In addition, the Governor has six appointments and the Senate President and House Speaker have two appointments each.

One of the principal responsibilities of Oklahoma Futures was the formulation of a five-year economic development plan for the state, which was adopted in January of 1988 and serves as the primary program for the Department of Commerce.

Those from the Tulsa area who presently serve, in addition to Cole, are Chamber Directors G. Douglas Fox and L.F. Rooney, III; as well as Senate President Cullison; State Economic Development Chairman Ted Fisher; House Economic Development Chairman Don McCorkell; Janet Drummond and Hans Helmerich.

Legislative Wrap-Up

The Oklahoma legislature, following their newly mandated schedule, adjourned sine die at 5 p.m. on Friday, May 25, 1990. Though we suffered a few setbacks, the session would have to be considered a success for the Tulsa business community.

Tort Reform

● HB 1122 (Steidley/Miles-La-Grange)

Would have allowed plaintiffs to discover, for settlement purposes, the amount of insurance carried by a defendant. The Chamber opposed this legislation and the bill died in a conference committee.

Worker's Compensation

● SB 830 (D. Williams/Hudson)

Was signed by the Governor May 29 after quickly moving through both houses. Several attempts at more extensive Worker's Compensation reform were defeated during this session, bringing about this compromise bill. Though some of the changes will be beneficial to business (creation of an Advisory Council from business, labor and trial lawyers; creation of an ombudsman service for employees and small business), no benefit changes were made. The Worker's Compensation Study contains a number of additional recommendations which could receive consideration next year.

Economic Development

● HB 1950 (Roach/P. Williams)

Provides preferential treatment on linked deposit loans to firms located in enterprise zones. These loans are made at below market rates with monies set aside by the State Treasury. The Chamber strongly supported this bill signed by the Governor May 30.

● HB 2265 (McCorkell)

A one-time vehicle for comprehensive Worker's Compensation reform, was amended to contain a sales tax waiver for construction projects of new or expanding businesses. The waiver would have applied to materials used in these projects

provided they cost more than \$5 million and eventually employ more than 100 new workers. HB 2265 was one of the Chamber's priority economic development issues this session. Unfortunately, it was vetoed by the Governor on June 1.

● SB 443 (Ford/Rice)

Clarifies that the financing, construction, ownership or lease of a warehouse is a permissible public trust purpose if not used for alcoholic beverages. It was signed by the Governor on April 16.

● SB 684 (Fisher/Easley)

Modifies the state Competitive Bidding Act to exclude construction of improvements, or repair to private buildings or property leased for private use. This measure allows businesses under public trust financing to choose their own contractors for facility expansion. It was signed by the Governor May 1.

General

● HB 1042 (Stottlemire/Horner)

Included employees of municipalities with populations over 35,000 and permanent members of paid police departments among public employees not accorded the right to strike. It also would have allowed municipal employees the right to engage in collective bargaining. Though City of Tulsa employees already bargain collectively, the Chamber objected to the lack of flexibility this process provides. The bill died in committee.

● HB 1738 (Fisher/Easley)

Requires the Corporation Commission to open a full-service office in Tulsa for the purpose of accepting and processing applications for oil and gas development. This legislation was signed into law May 29.

● HB 2155 (Hale)

Removes the sunset provision on mandatory inspection of automobile emission equipment allowing Tulsa to meet EPA requirements. HB 2155 was signed by the Governor May 30.

● SB 589 (Easley/Rozell)

Establishes a Tulsa field office of the state Department of Commerce and

calls for a study of the reorganization and redistribution of government services across the state. It was signed by the Governor May 29.

● SB 709 (Smith/Cozart)

Allows counties with a population of more than 300,000 to modify the maximum sales tax they may levy from 1% to .5% for the use of providing more jail facilities. SB 709 was signed into law May 7.

Health

Continued from Page 1

single coverage and 15 percent for family coverage, compared to indemnity plan increases averaging 20 percent for single coverage and 22 percent for family coverage.

Nationally, the average increase in premiums reported by company executives is 20 percent over the previous year's premiums, according to the May 15 issue of Medical Benefits.

Pricing Patterns

HMO monthly premiums averaged \$104 for single coverage - ranging from \$78 to \$118 a month.

Family coverage under an HMO averaged \$270. Again, the monthly premiums varied substantially from company to company; the highest premium reported by a company was \$405, the lowest was \$226.

Indemnity plans averaged \$101 a month for single coverage - ranging from \$78 to \$122 a month.

Family coverage averaged \$280 for indemnity plans - the highest premium reported in this category was \$329 and the lowest was \$129.

Tulsa Business Health Group members include:

American Airlines, Doesche McDermott, City of Tulsa, Helmerich & Payne Inc., Newspaper Printing, OXY USA Inc., Purolator Products, Sun Refining & Marketing, University of Tulsa.

Also Zebco, Badger Meter Inc., Citgo, First National Bank, McDonnell Douglas, ONEOK, Public Service Company, Samson Industries, Tulsa Public Schools, Williams Companies.

ELLIS & ASSOCIATES

Employee Benefit • Analysts & Brokers

Dennis E. Eckart
United States House of Representatives
Committee on Small Business
1210 Longworth House Office Building
Washington, D.C. 20515-3511
FAX Number: (202) 225-1514

Dear Congressman Eckart:

Thank you for your invitation to address your sub-committee relating to the difficulties facing the small business in obtaining affordable health care.

As you are well aware, the small business and the self employed individual is having an increasingly more difficult time in both finding coverage for their health care and in being able to afford the coverage.

Scores of studies have been done and not a week goes by that articles are written regarding this problem. It seems as though there are as many opinions about the subject as there are those that wish to study or write about the dilemma.

Over the last several years we have seen a general inflation rate of between 3 and 5% while the medical inflation rate has been ranging between 18 and 36%, as deemed by the insurance industry. Health insurance renewal rates are presently ranging between 9 and 50%.

As an agent/broker of health insurance plans it is my obligation to my clients to help them obtain the best medical insurance program at the most reasonable price. Not only is the job more challenging but it is also more and more frustrating. Employers, particularly the small employer cannot afford to pay premiums of

\$250 to \$350 in family coverage for their employees.

In one recent newspaper article by Jane Bryant Guinn, the insurer for the Denver area's Shared Cost Option for Private Employers (SCOPE) program is the same insurer that is raising the monthly premium of one of my small business clients in Tulsa by 50%. Therefore, it seems as though the insurer has entered into an agreement that benefits those in one local, while at the same time increasing rates of those in another local.

It has taken many years for the health care system to deteriorate to our current level and there are many factors involve in this crisis. The following are a few of the causes:

- 1) Medicare and Medicaid has provided benefits to many that have never contributed to the system.
- 2) Some insurance companies promoting "HOT" new products knowing full well the premiums will drastically increase in 6 to 12 months, for those buying the program. Or the company will pull the product from the market within a few years. In this way the company can escalate the premiums so dramatically the insured must drop the policy due to expense. Then the insured must try to replace the policy only to find that his/her pre-existing conditions will not be covered.

Or in the case of one locally based insurance company that boldly markets a small business association (SBA) plan, I found after looking at the financials of this organization that their reserve fund in 1986 listed less than \$50,000.

- 3) Agents selling products they know nothing about or worse, selling products from undercapitalized companies because of higher commissions and unrealistically low premiums.
- 4) Employers buying health care plans based solely on premium.
- 5) Escalating physician and hospital cost, and some instances of providers billing patients for amounts in excess of agreed upon discounts made between the insurance companies and the provider.

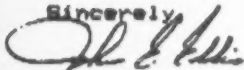
Hospitals in the Tulsa area have not been afforded the same treatment as hospitals in the Oklahoma City area. (ie Our hospitals have been expected to treat indigent patients while being reimbursed by the state a much smaller percentage of the costs than that percentage the state reimburses the Oklahoma City hospitals.

- 6) Escalating malpractice insurance costs to providers due to lack of legislative intervention in capping the amounts recoverable in malpractice litigation.

If a solution to our national health care crisis is to be found, a concerted effort must be made by all. The citizenry; insurance companies; agents; local, state, and national elected officials; employers and employees; and health care providers must come together. We cannot expect the insurance companies or health care providers to stay in business unless they are

profitable. In the same token, the small business cannot be expected to bear all the costs either. I therefore believe that the states must standardize their criteria in dealing with insurance companies and agents, health care providers, and uninsurable individuals. Pooling of resources and pooling of the medically indigent in conjunction with mandatory insurance carrier participation of basic health care plans, may provide some badly needed stability to our health care system.

Sincerely,



John E. Ellis



Health Insurance Association of America

STATEMENT OF HIAA

ON

HEALTH INSURANCE IN THE SMALL EMPLOYER MARKET

SUBMITTED TO THE

SUBCOMMITTEE ON ANTITRUST, IMPACT OF DEREGULATION, AND PRIVATIZATION

COMMITTEE ON SMALL BUSINESS

U.S. HOUSE OF REPRESENTATIVES

AUGUST 10, 1990

1025 Connecticut Avenue, NW
Washington, D.C. 20036-3998
(202) 224-7780

The Health Insurance Association of America is a trade association of 320 private health insurance companies which provide health insurance for 95 million Americans. The HIAA has presented its overall proposal for extending health care benefits to uninsured Americans at numerous Congressional forums. These remarks are specifically directed to the health insurance problems of small employers and the working uninsured.

As you know, the uninsured population includes large numbers of workers and their dependents, many of whom are concentrated in the small employer market. While most insured people enjoy coverage through the workplace, there are a substantial number of the uninsured who are not offered, or otherwise do not elect such coverage. In fact, three-quarters of the uninsured, are themselves workers or are members of families with workers. Of these, most are employed full-time. Two out of three of the employed uninsured work in smaller establishments having fewer than 25 employees (1987 National Medical Expenditure Survey).

According to our own survey, in 1989 only 39 percent of firms with fewer than 25 employees offered health benefits, citing cost as the primary deterrent. These very small businesses tend to be plagued with problems of high labor turnover, low profits and high failure rates. Further, many of the employed uninsured have low incomes which would preclude them from purchasing individual coverage. Three out of four of the uninsured workers earn less than \$10,000 annually. These factors all contribute to the increasing difficulty of being able to offer health insurance coverage to employees of small businesses.

Mr. Chairman, we share your concern over the problems increasingly encountered by small employers seeking to obtain or retain affordable coverage for their employees. To seek relief from rising health care costs, many small employers have more aggressively sought the lowest priced health care coverage possible. Those with healthy employees more often seek and obtain coverage at a low price reflecting their low risk. In turn, more and more insurers have found that, to be price competitive for these employers, they cannot spread the costs of groups with high medical expenses to these low risk employers. Eventually, however, healthy groups with low priced coverage reflecting their low risks face large price increases when some employees' health deteriorates. And a growing number of small employers with high risk employees will not be able to find coverage at an affordable price. Some such employers may obtain affordable coverage for the rest of their employees by leaving their sickest employees without coverage for their health care needs. These phenomena are occurring because of rational economic behavior to seek the lowest short-term price possible, combined with the inadequate risk-spreading base afforded by any one small group.

Mr. Chairman, we have now reached the point where substantial small employer market reforms are needed if we are to serve the broader interests of small employers and meet the concerns of policymakers. We have developed and are recommending a comprehensive set of legislative reforms that we believe can be implemented while sustaining a viable private marketplace. Our

proposals would enable all employers with 25 or fewer employees to obtain relatively affordable private health coverage. Let me emphasize that, to work, these new rules will have to pertain to all competitors in the small employer market. If any one company or one segment of the market pursues these reforms independently, without rules for marketplace behavior spelled out in legislation, it would probably be inviting financial ruin.

The small employer market reforms we recommend were developed by a special Board Committee -- the HIAA Board Committee on Reinsurance -- and have been approved by the full HIAA Board. They are as follows:

1. Private coverage would be made available to entire employer groups. Neither employers nor insurers could exclude an individual from a group's coverage because they present a high medical risk.
2. At renewal time, employer groups and/or individuals within these groups would be assured that their coverage would not be cancelled because their health deteriorates.
3. Given the frequency with which small employers change carriers and employees in this market change jobs, individuals should have greater protection when making such moves. Therefore, once an individual has health insurance and has met initial preexisting condition restrictions, he or

she would not be faced with new restrictions in the event that they change jobs or their employer changes carriers.

4. There would be specific limits on how much an insurance carrier's rates could vary for employer groups of similar composition (similar demography, geography and benefit design). Further, there would be limits on rate variations by industry. The proposal would involve limits on how much a carrier could raise its rates for a specific group above and beyond general increases in trend factors.
5. Insurance carriers would retain the right to medically underwrite for purposes of assessing risk, setting rates and determining use of reinsurance, but not to exclude individuals from coverage in a group plan.
6. Finally, a major objective of these reforms should be to ensure a viable private marketplace over the long term.

What health insurers will require of government is appropriate authorization for a private not-for-profit reinsurance organization to be established. These reforms are not achievable without such a mechanism. This organization would allow carriers to pay a premium in exchange for having the reinsurer bear the risk for reinsured persons. Consistent with our recommended small employer market reforms, the proposal would not allow breaking up groups for purposes of reinsurance. Rather, insurers would treat

all individuals in a group the same way; all members would have the same benefits. The reinsurer would stand behind the carrier and simply reimburse for claims associated with reinsured persons. This will allow us to assure that high risks are spread broadly across the private market rather than be isolated on one small employer group.

The reinsurance mechanism would naturally sustain financial losses or shortfalls, since carriers would reinsure only cases whose claims are expected to exceed the price of reinsurance. The intent of the proposal is that losses be financed privately. Losses first would be spread across carriers in the small employer market up to four percent of premium. We have designed a reinsurance structure which should constrain losses to within this four percent level. However, if losses were not absorbed fully by the small employer market, a second tier of losses would be spread across health benefit plans of small and large employers, up to one percent of premium and premium equivalent. This would provide a private financing safety cushion that is larger than the basic intended funding source. In the highly unlikely event that the second tier was inadequate to absorb reinsurer losses, we would request that a safety valve -- broad-based government funding -- be made available.

These proposed reforms will assure that no small employer, and no employee of a small employer, will be turned down for health insurance because of poor health. They will restore the

concept of pooling risk across large populations, greatly limiting how much of the cost of poor health must be borne by the individual employer. And they will moderate significantly the sometimes dramatic premium increases now experienced by small employers at renewal time and thereby reduce the incentive to change carriers frequently.

There are further steps that Congress should take now to assist small employers with the high cost of health care.

First, the existing pre-emption of state mandatory benefit laws that currently applies to self-insured employee health plans should be extended to insured plans. There are over 800 different state mandated benefit laws nationwide, ranging from chinese medicine to pastoral counseling and from wigs to in vitro fertilization. The cumulative effect is a hodgepodge of state laws that increase the cost of health insurance to small employers who are most in need of relief from the high cost of health care. Small employers should not be forced to choose between a "Cadillac" plan and none at all.

A study by a respected health economist at the University of Illinois estimates that as many as 16 percent of uninsured small employers fail to offer coverage because of the added expense resulting from state mandates.

Second, owner-employees of small businesses should not be forced to incorporate to get a 100 percent deduction for their health insurance plan. The 25 percent deduction which expires this year should be extended and increased, giving self-employed individuals a 100 percent deduction for their health insurance protection as long as they provide equal coverage to their employees, if any.

Third, as part of a Medicaid reform package, we recommend that all Americans with family income below the poverty line be covered by Medicaid. Further, federal rules should allow state Medicaid programs to pay the employee share of premiums for all poor workers covered by employer plans for which government savings would exceed outlays.

Mr. Chairman, I want to emphasize to you that it is definitely not business as usual in the insurance industry. Besides our recommended legislative reforms for the small employer insurance market, the nation's insurers are moving on their own against what we know to be the root cause of so many of our problems, the ever spiralling cost of health care. Our companies are making, and have already made, major investments to develop their capacity for managed care. They are devoting major resources to obtaining better value for the health care dollar. The information technology that becomes more sophisticated each day increases our ability to make sound judgements on value, on quality, on underutilization as well as overutilization, on

efficacy and outcomes. This role is a very different one from the traditional health insurer role our companies previously fulfilled.

We recognize that there is no magic bullet to solve the egregious problem of unacceptable health care cost escalation. However, we in the private sector recognize vividly that there is a substantial problem and have developed a very effective private sector tool which is just beginning to be used.

Will it work? Our nation's business leaders think so. According to a survey of Fortune 1000 senior executives conducted by the Roper Organization, Inc., more than two-thirds (68 percent) believe that managing health costs through networks such as health maintenance organizations and preferred provider organizations is, or could be, effective; 89 percent of the executives polled have made changes in their corporate health plans targeted at containing costs; and an overwhelming 94 percent oppose national health insurance as a solution for the escalating health financing crisis. The vast majority clearly think the private sector should take responsibility for solving their health care financing crisis. Working together with government, we think we can make a substantially better tomorrow for us all.

Thank you.

ESECO Speedmaster.

918-225-1286

1 ESECO ROAD Cushing, OK 74023

August 8, 1990

Congressman Dennis Eckart
Chairman House Small Business Subcommittee
Antitrust, Impact of Deregulation and Privatization
Subject: Medical Benefits Program

Employee coverage was provided at 50/50 basis \$250 deductible with the company adding 10% to its contribution for each year of service. A five year employee had a fully paid plan for and family. It covered 80/20 up to \$3,000.00 and 100% thereafter. It also covered \$10,000 life insurance, 90 day loss of income and dental up to \$1,000 a year per person.

	The premiums: Monthly	Annual
1986	\$5761	\$69,132
1987	\$6733	\$80,790
1988	\$6750	\$81,000

The quotation came in for renewal at \$14,750 and we looked for alternatives. We had 17 years experience with the carrier and effective loss ratio of less than 60% during that period.

We discontinued the plan of 100% company contribution and went to a maximum of 50/50. To get the following rates we self insured the dental and short term disability benefits at a cost of \$24,000 per year to the company, and \$300.00 deductible.

1989 1/2	\$7,777	\$93,324
1989 2nd 1/2	\$8,000	\$96,000*

To contain that rate increase which was scheduled to be increased to \$9,100 a month premium, the company agreed to \$1,000 deductible and it subsidized the employee benefit for the \$700 difference or an exposure of \$51,000 per year.

1990 1/2	\$9299	\$111,588
1990 2nd 1/2	\$12,188	\$146,256



Cable Address - ESECO CUSH UD
Telex Address - 704205
Fax Number - 1 918 225 1284

Electronic Systems Engineering Co. CUSHING OKLAHOMA 74023

During this short time span the costs have more than doubled, the employees are sharing half of the burden which further reduces their spendable income. Notwithstanding that fact the company contribution of over \$73,000 plus the extra provisions for dental and disability income protection which amounts to \$75,000 per year actually places the total cost at \$221,000 or over \$4,000 per year per employee.

Ours is a small business, sales volume of \$3.5 million, embarking on a vigorous and costly export program. Employment stands at 63, group participants 39 families.

The direct affect is an erosion of profit of over \$140,000 a year (4%). The loss of federal and state income tax revenues currently estimated at \$50,000 a year. Unless prompt and decisive remedies are provided our company will not be able to survive with the added expense burden and will be faced with the unpleasant choice of discontinuing all medical benefit programs.

Respectfully submitted,

Arthur A. Kaminshine
Arthur A. Kaminshine, President

